The RHODE ISLAND MEDICAL JOURNAL

VOL. XLIII MAY, 1960 NO. 5

THE CARE OF THE AGED IN ISRAEL

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Doctor Burgess recently returned from a month's visit to Israel as member of an exchange team of Rhode Island physicians from the staff of Miriam Hospital, Providence. He is chairman of the State Conference on Aging for Rhode Island, and therefore this short summary of the care of the elderly in Israel is of particular interest.

... THE EDITORS

* * *

ISRAEL, newly established as an independent nation, small, surrounded by enemies, and low in natural resources, has accomplished things that have seemed almost impossible. The defeat of invading armies, the control of endemic disease, and the reception and care of hoards of immigrants are spectacular achievements. Less well known, but by no means the least of its accomplishments, is Israel's care of its aged and infirm citizens. This might well serve as a model which many more prosperous countries would be wise to imitate.

The great majority of elderly Israeli citizens who need assistance are found among those who have immigrated to the country since the establishment of the independent state in May, 1948. Aid to this group is one of the functions of Malben, the executive organization in Israel of the American Joint Distribution Committee. While this Committee is represented in Israel by Malben, its home headquarters are in New York, and its operative headquarters in Paris. This report is concerned with the work of this organization in dealing with the problems of the elderly immigrants of whom there are said to be about five thousand in Israel at the present time.

Eligibility for such aid is established on the basis of the following criteria: (1) Age and (2) Social need, which includes financial and other handicaps such as physical disability. To qualify as to age, a woman must be at least 60 years old, while a man must have reached the age of 65 years, at the time of their arrival in Israel. The second factor, social need, is determined by careful studies as described below.

When accepted, the recipient of assistance is classified in one of the following four groups:

1. Able-bodied aged.
2. Infirm aged, requiring non-skilled assistance.
3. Persons requiring attention of trained nurses.
4. Chronically ill patients who need hospitalization.

People in groups 1, 2, and 3 can be cared for in homes for the aged while those in the 4th category are placed in hospitals for chronic diseases which are operated either as separate institutions or as annexes to general hospitals. When a patient who has been accepted for care by Malben develops an acute medical or surgical condition requiring more than four or five days in a sick bay such as is found in the larger institutions, he is transferred to a hospital for acute diseases.

Admission to care by Malben is accomplished as follows: The social worker in the area in which an elderly person resides for whom she deems such care is appropriate fills out a detailed form which describes the patient and his needs. This form she sends to the central office in Tel Aviv where it is carefully studied jointly by a physician and a Malben social worker. If at this point eligibility is found, the social worker goes to the home of the person and further checks on the situation. She then arranges for a medical assessment of the applicant in an Out-patient Clinic or, if need be, for a hospital admission for more complete study.

In case the physician and social worker do not find that the person is eligible, the application form is passed on to a higher authority, the Admission Board, which will further attempt to assess the person's needs and which is authorized to recommend special consideration of his problem if it sees fit. After this the report goes to the Admission Board which sits weekly. At this meeting the social worker who saw the patient is present. The director of the Department for Care of the Aged of Malben is chairman, and a number of responsible officials participate. Agreement is almost always reached

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without difficulty.

When accepted for care a person is studied to determine his work ability. If it is found that he is able to work, even for a short time each day, arrangements are made for him to do so. As far as possible, this work is along the line of his training or profession. Thus, for example, a number of physicians who receive aid from Malben are working as doctors in old age homes and clinics. Besides aiding in obtaining employment for its clients both inside and outside its institutions, Malben also carries out a program of extramural care for the aged. This involves such things as aid in obtaining adequate housing, provision for various interests of elderly people in their daily lives, the organization of clubs (there are slightly over thirty "Golden-Age Clubs" in Israel) and in many instances day care in appropriate institutions from which the people can return to their own homes at night. The subject of providing "meals on wheels," that is, the delivery of at least one hot meal a day to the elderly in their own homes, is being studied, but a definite plan has not yet been made to accomplish this.

It is of interest that in the homes for the aged there are over 400 diabetics and no cases of diabetic coma have occurred. Also, an equal number of definite or suspicious cases of glaucoma have been found. For the treatment of these and other conditions, specialist consultants are available to supervise treatment. Of course there are many instances of malignant tumors, and these patients are made as comfortable and happy as possible when definitive therapy is not feasible. For radium or X-ray therapy, twenty beds are maintained on contract with a French (Catholic) hospital in Jerusalem where the patients are cared for most kindly by the nuns. Chronic cardiac disease is also common in the group, but pulmonary edema, which used to be of frequent occurrence, is now relatively rare. A study of pulmonary insufficiency is to be carried out in the future.

Psychiatric problems are not uncommon among the elderly group. It has been emphasized that about 90 per cent of these are of environmental origin and can be improved or even corrected by proper management. In definite psychiatric cases assessment by a specialist is indicated, and a very able expert in this field is available.

This physician heads a geriatric psychiatric service for the whole country. It is now noted that the average hospital stay of a person referred for care by this department is but forty days and readmissions are rare. In addition, day care for milder psychiatric conditions is available.

Doctor M. Schadel, supervisor of Medical Services in Old Age Homes and Infirmaries, supplied the information contained in this report. The Medical Department of Malben has organized training in the geriatric field for physicians and training has also been organized for nurses, house mothers, and even for administrators. He has emphasized the value in dealing with an elderly individual who is emotionally upset, of sitting down and listening with an attitude of helpful respect. In this and in other phases of the work he has pointed out the value of arranging for a person to do work of which he is capable and to receive some pay for his work. A good example of this is a man who is a retired postmaster. He is in a small geriatric community run by Malben, in which he is the postmaster.

Recreation is provided in the homes for the aged —games, theater, dancing, and occupational therapy of many kinds. Bible reading for the highly religious is held, and there is a synagogue in every institution.

Nutritional needs are carefully fulfilled, no easy task when dealing with groups whose tastes, habits, national origins, and customs vary so greatly. This problem will disappear as succeeding generations become old, but among the present immigrant elderly it is very real.

The writer was privileged to visit the Nwey-Avoth Home and Hospital, one of the larger of the Malben installations in company with Doctor Schadel. It occupies an area of 70 acres in the town of Pardes Hana about 40 miles north of Tel Aviv. In four years a garden community of one-story houses has been created for both able-bodied elderly people and those who require nursing care. There are 1,100 men and women living there in homelike conditions. Their rooms are bright and attractive and their houses surrounded by gardens for which they care.

There are three sections of this community, each with its administration, dining rooms, and other facilities. All these sections contain a majority of able-bodied individuals. Although these people are not required to work, practically all of them do. They can earn a little money by their work which adds to their sense of accomplishment and independence.

Indoor and outdoor occupations are available including care of the gardens and various tasks about the premises, as well as weaving, knitting, ceramics, and the like. "A sense of contributing according to ability and interests and great respect for personality—bright smiles and a general sense of happy adjusted people," to quote from notes made by Mrs. Burgess.

It was gratifying to see these people at their various tasks indoors and outdoors and to realize that they were in many instances doing things in line with their skills and inclinations. One elderly man, for example, who had been a bus driver, was in charge of a tractor with which he hauled mate-

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The RHODE ISLAND MEDICAL JOURNAL

Editorial and Business Office: 106 Francis Street, Providence, R. I.

Editor-in-Chief: JOHN E. DONLEY, M.D.

Associate Editors-in-Chief

ALEX M. BURGESS, SR., M.D., HENRI E. GAUTHIER, M.D., SEEBERT J. GOLDOWSKY, M.D.

Managing Editor: JOHN E. FARRELL

Owned and Published Monthly by

THE RHODE ISLAND MEDICAL SOCIETY

Second-class postage paid at Providence, Rhode Island

Single copies, 25 cents . . . Subscription, $2.00 per year.

Volume XLIII, No. 5 May, 1960

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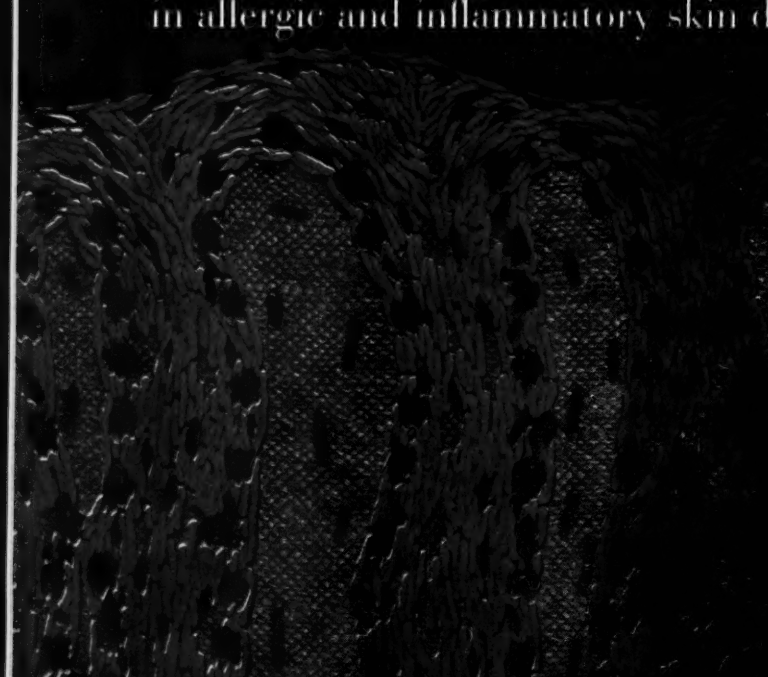

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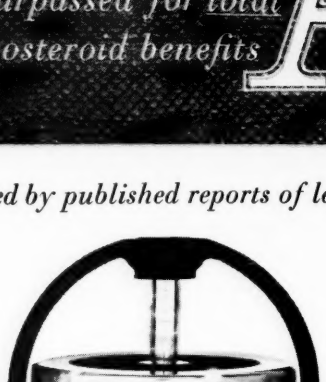

- biochemical and psychic balance disturbance minimal[1, 4-18]

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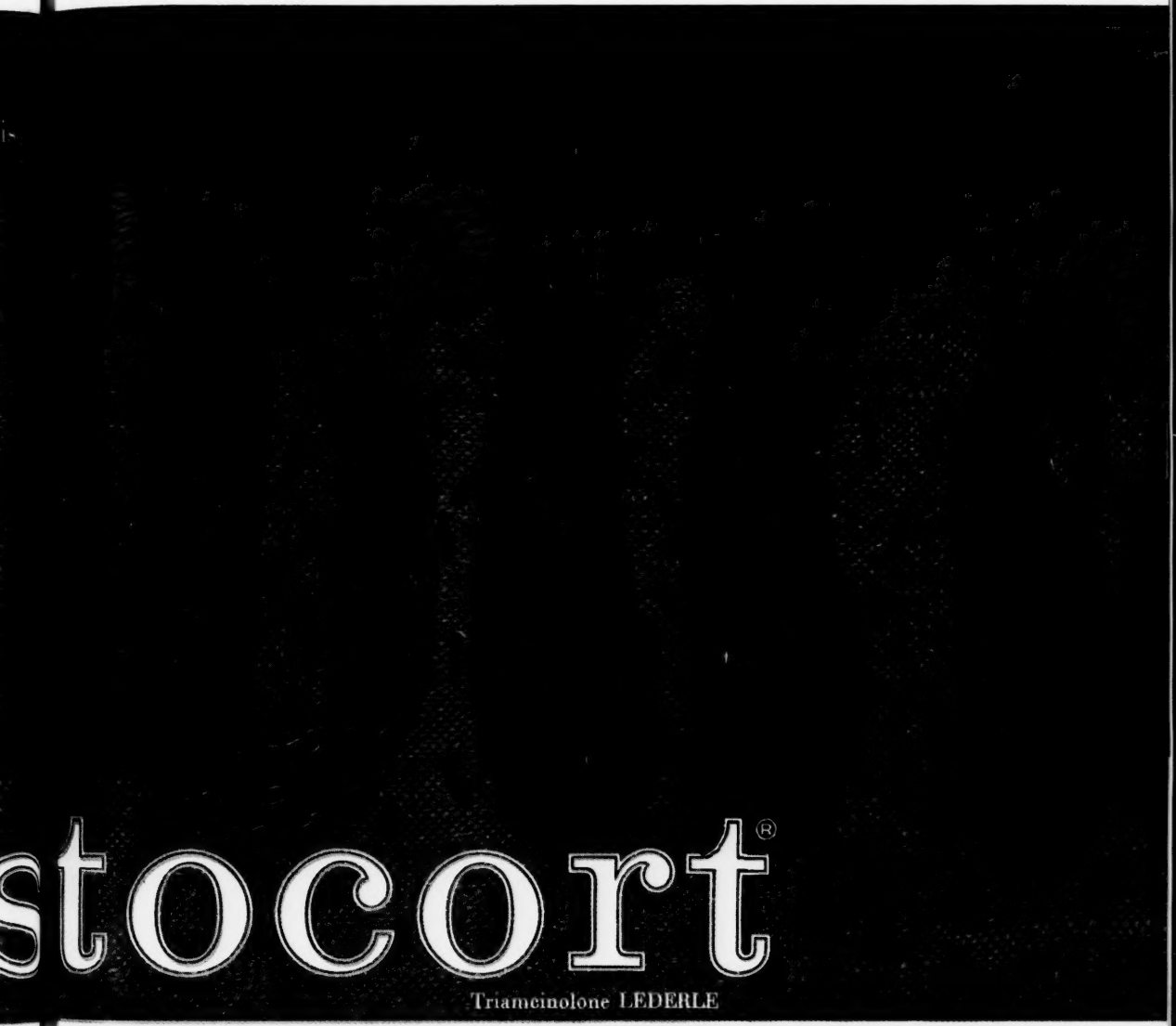

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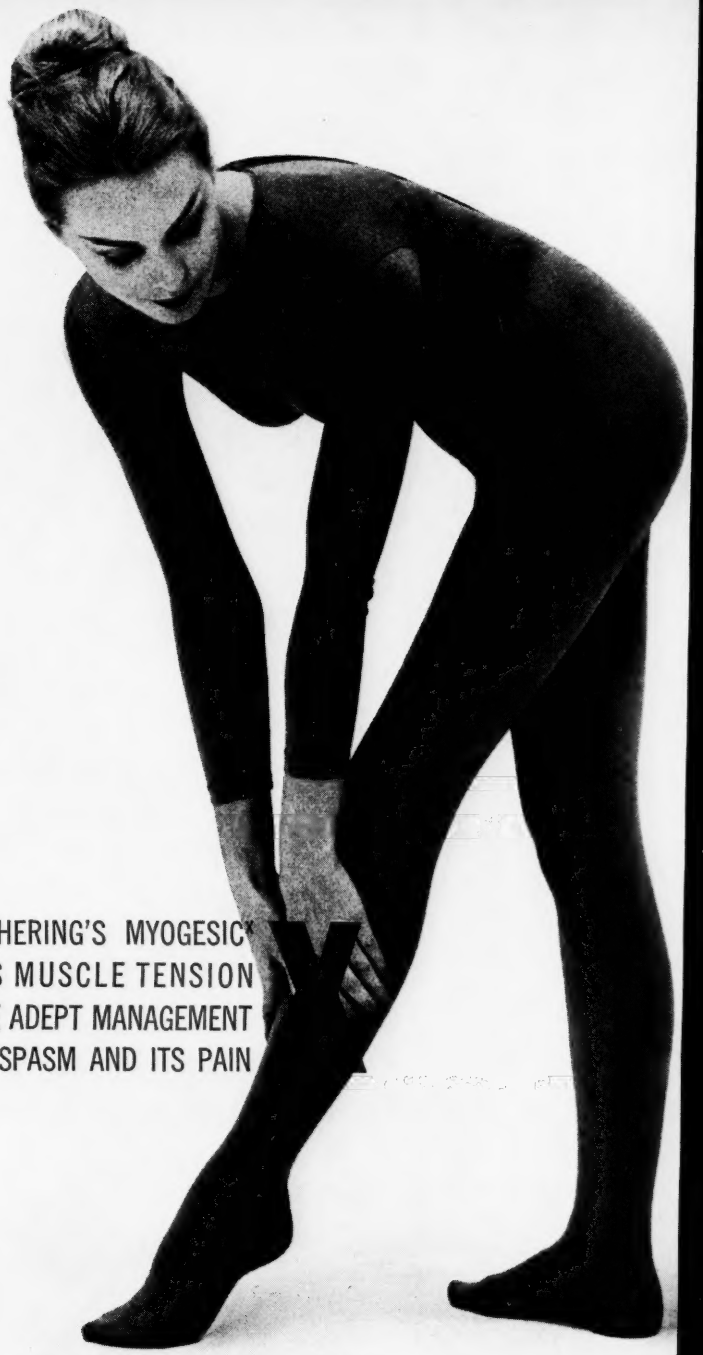

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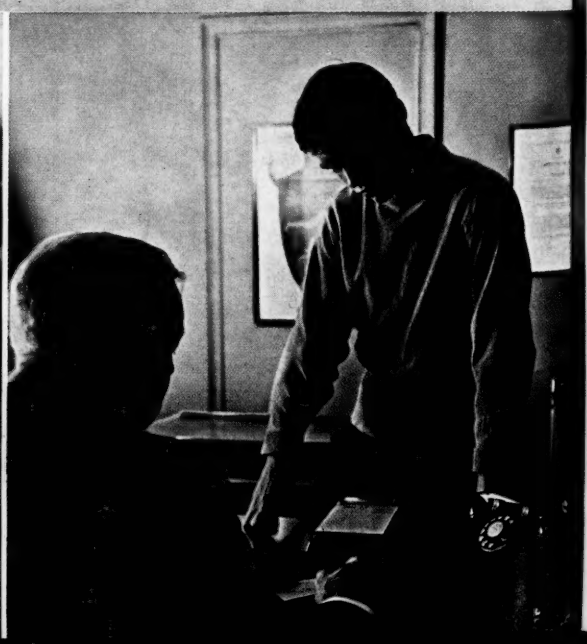

LERICHE'S SYNDROME*

Review of Clinical Features and Surgical Treatment

LESTER L. VARGAS, M.D., AND WILLIAM P. CORVESE, M.D.

The Authors. *Lester L. Vargas, M.D., Director, Cardiovascular Surgery, Department of Surgery; William P. Corvese, M.D., Assistant Surgeon, Section on Cardiovascular Surgery, Department of Surgery, Rhode Island Hospital.*

ARTERIOSCLEROTIC OCCLUSION of the terminal aorta is a chronic, progressive, incapacitating disease which is surgically remediable. In 1940 Leriche[1] was the first to call attention to the clinical syndrome, although Graham[2] in 1814 and Welch[3] in 1899 had described the disease as a pathological entity. Originally this crippling disease was considered to be uncommon. However, as a result of a growing interest in cardiovascular surgery and the wider use of aortography, an increasing number of reports have appeared.[4-16] It would appear that the condition occurs more frequently than was previously appreciated. It is our purpose to review the clinical features of arteriosclerotic aorto-iliac occlusion and to illustrate its surgical management with the presentation of three cases.

Clinical Features

The basic pathological lesion is atherosclerosis of the distal aorta and proximal iliac arteries. Thrombi develop upon the degenerated and frequently ulcerated lesions which narrow the lumen of the vessels and predispose them to further thrombotic occlusion. The thrombus may be deposited in several layers before occlusion is complete. Stenosis of the terminal aorta and iliac vessels usually develops slowly, but sometimes sudden complete obstruction by a fresh thrombus occurs.[17] Proximal and distal propagation of the thrombus occludes important collateral vessels resulting in progressive ischemia of the lower extremities and ultimately leads to gangrene.

Pain is the predominant clinical symptom. Bilateral intermittent claudication of the calves, thighs and hips usually develops insidiously. At first the patient may only complain of a sense of weight and fatigue in the legs. Sometimes an acute onset of pain and a clinical picture indistinguishable from embolic occlusion of the aortic bifurcation first brings the patient to the attention of the physician. Both femoral pulses are absent when obstruction is complete. Diminution or absence of one femoral pulse may indicate an incomplete occlusion. The inability of the male patient to maintain a sustained erection, resulting in impotence, is frequently encountered. An interesting feature of this syndrome is the absence of significant nutritional changes in the distal extremities in spite of complete aortic occlusion and relatively few symptoms. Atrophy and other evidence of ischemic necrosis occur late in the course of the disease only after major collateral channels have been occluded. Elevation of systemic blood pressure proximal to the occlusion together with systolic bruits over the involved vessels also occur.

An accurate diagnosis of Leriche's Syndrome can usually be made from the clinical features of the disease. Failure to palpate the patient's pulses frequently results in mistaken diagnoses such as, back strain, herniated intervertebral disc, arthritis, myalgia, and psychic impotence. In most cases aortography will precisely delineate the extent of the aorto-iliac occlusion. The direct injection of a contrast medium into the obstructed aorta, however, is not without hazard. With increasing experience, many cardiovascular surgeons now prefer operative exploration with distal arteriography as a safer procedure.

Early efforts by Leriche in treating this disease were directed toward limiting propagation of the atheromatous process by excising the diseased vascular segments with proximal and distal ligation. At the same time bilateral high lumbar sympathectomy was performed to enhance collateral blood flow. Although he reported success with this method, his results could not be duplicated by other surgeons.

As early as 1923, Leriche[18] suggested restoring vascular continuity with a graft. Although the feasibility of blood vessel grafting had been demonstrated in the laboratory by Carrel[19] and others,[20] it was not until 27 years later that Oudot[21] successfully utilized a preserved homologous artery graft clinically. Since then Julian,[22] Brock,[23] DeBakey and his associates,[24,25] and Deterling[26] have utilized and extended the scope of this method of

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treating aorto-iliac occlusion.

In 1947 a Portuguese surgeon, Dos Santos,[27] demonstrated that thromboendarterectomy was an effective method of restoring vascular continuity in occluded arteries. This method was subsequently utilized successfully in the treatment of terminal aortic thrombosis by Basy,[28] Lemaire,[29] Wylie,[30,31] Julian[32] and Barker.[33] The changes occurring in the artery following the surgical removal of its intima and occluding atheroma have been described by Wylie and his associates.[30] The vessel is immediately lined with fibrinous clot which is confined to the periphery by the high velocity blood flow. Host fibroblasts then invade the fibrin matrix and become modified. By the fifth week these cells are indistinguishable from those of normal intima. Initially some authors suggested that the blood vessel wall, remaining after the excision of the atherosclerotic intima, required re-enforcement with autogenous[30] or synthetic[34] material. Experience has shown this to be unnecessary. Cases followed for reasonable lengths of time have not shown a tendency to dilate or become aneurysmal.[35] This technique is particularly suited in cases where atheromatous obstruction is limited to the terminal aorta and the common iliac arteries. It is a procedure that can be performed more rapidly than blood vessel grafting and it eliminates the need for a homograft or synthetic prosthesis which acts as a foreign body. In some cases atheromatous degeneration of the arterial wall is so extensive that endarterectomy is technically impossible because of fragmentation and tearing of the residual media and adventitia. The surgeon employing endarterectomy in the treatment of Leriche's Syndrome must be prepared to abandon the method and utilize a graft whenever the diseased vessels are found to be unsuitable.

Case Reports

Case 1. I. M. (R.I.H. 599412). A 58-year-old woman had had intermittent pain in her hips and thighs for five months. The pain characteristically occurred only with exercise and was promptly relieved by rest. She had consulted several physicians who had prescribed quinine and physiotherapy for her. In the month preceding admission she had noted persistent coldness of her legs and intermittent numbness. Increasing incapacity finally led to her admission to the hospital on July 29, 1958.

Examination disclosed bilateral absence of femoral, popliteal and pedal pulses. The abdominal aortic pulse could be felt only high in the epigastrium. The forefeet and toes were cool and slightly cyanotic. Blood pressure was 130/70 mm. Hg. There were no other significant abnormalities noted in the cardiovascular system. A percutaneous translumbar aortogram showed complete occlusion of the distal abdominal aorta and proximal common iliac arteries (Figure 1). An electrocardiogram was reported as being within normal limits.

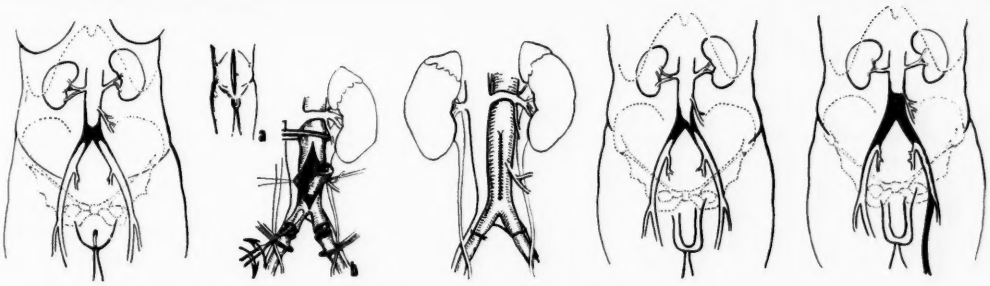
On August 6, 1958, the abdomen was entered through a long midline incision extending from the xiphoid to the pubes (Figure 2a). The posterior parietal peritoneum was incised to expose the abdominal aorta and iliac vessels. Mobilization of these vessels was performed with some difficulty because of firm perivascular adhesions. The aorta and common iliac arteries were clamped proximal and distal to the area of thrombotic occlusion. An aorto-iliac endarterectomy was then carried out in the occluded arteries (Figure 2b). After repairing the arteriotomy sites with fine atraumatic silk (Figure 3) and releasing the occluding clamps, all lower extremity pulses were immediately restored.

Postoperatively her course was complicated by intestinal ileus and electrolyte imbalance. An unexplained fall in her serum proteins resulted in transient peripheral edema. However, she continued to improve and was discharged three weeks following operation. In the eighteen months since surgery she has returned to full activity and has no symptoms referable to her lower extremities.

Case 2. J. M. (R.I.H. 608565). A 38-year-old laborer was admitted on January 14, 1959. He had noted bilateral mild intermittent claudication in his thighs and legs for several years. Three months prior to admission the pain in his right lower extremity had become severe and he had noted increasing coldness and numbness in both legs. He had been impotent for one year.

Examination revealed that all pulses were absent in his right lower extremity. Only a faint femoral pulse could be felt on the left. The right leg was cooler than the left. Blood pressure was 130/80 mm. Hg. A systolic murmur was audible over the umbilicus. There was no clinical evidence of cardiac disease. An aortogram was attempted but abandoned because of extravasation of the radio-opaque medium. Soft tissue contrast roentgenograms of the lumbosacral region showed no evidence of calcification in the abdominal or pelvic arteries. An electrocardiogram revealed a normal sinus rhythm.

On January 16, 1959, the aortic bifurcation was exposed through a long midline abdominal incision. The right common iliac artery was completely obstructed for a distance of two centimeters from the aorta. The atheromatous process extended into the terminal aorta which was severely narrowed. The left common iliac artery was stenosed at its origin (Figure 4). A thrombo-endarterectomy was performed in a manner similar to that described in Case 1. All lower extremity pulses were completely restored. The patient walked on his fourth postoperative day and was discharged from the hospital nine days later. One month after operation he re-



FIGURES 1, 2a, 2b, 3, 4 AND 5

Figure 1. Drawing indicating the site and extent of aorto-iliac occlusion in Case 1.

Figure 2a. Operative incision required for adequate exposure of the abdominal aorta and its major branches.

Figure 2b. Schematic representation of the technique of aorto-iliac endarterectomy. The atheromatous core is separated in the plane between the intima and media of the artery.

Figure 3. Appearance of the aorta and iliac arteries after thromboendarterectomy. The arteriotomies are repaired with #4-0 silk. No reenforcement of the vessel wall is employed.

Figure 4. Drawing indicating the findings at operation in Case 2.

Figure 5. The distribution of the arteriosclerotic occlusive process encountered at operation in Case 3.

turned to heavy work as a laborer in a wire factory. He has regained his sexual vigor and has been asymptomatic to this date.

Case 3. J. J. (R.I.H. 616335). A 44-year-old business executive was said to have had a myocardial infarction at age 34. Except for occasional episodes of "angina pectoris," he had enjoyed good health until one and one-half years before admission. At that time he noted the abrupt onset of transient severe pain in his right buttock and lower extremity while playing golf. Later he developed bilateral intermittent claudication and weakness in his legs. He had been impotent for nine months. Increasing severity of his symptoms led to his admission on January 18, 1959.

Examination revealed a slightly obese male with a blood pressure of 140/80 mm. Hg. There was bilateral absence of femoral, popliteal and pedal pulses. The legs were cool but showed no atrophy. On elevation there was marked pallor of the feet. When dependent, the lower legs and feet were cyanotic. Capillary flushing time was 12 seconds bilaterally. An aortogram was unsatisfactory because of inadequate dye concentration. Lateral roentgenographic views of the lumbosacral area did not show calcification in the abdominal aorta or its major branches. An electrocardiogram showed no evidence of previous myocardial damage.

At operation on January 26, 1959, the distal aorta was found to be extensively thrombosed to the level of the inferior mesenteric artery. A well-organized thrombus extended beyond the bifurcation into the proximal common iliac arteries for a distance of approximately 3 centimeters (Figure 5). A satisfactory endarterectomy of the diseased vessels and bilateral lumbar sympathectomy were performed. Immediately after operation all pulses in the right lower extremity were easily felt. The left femoral pulse was strong but the popliteal and pedal pulses were absent. There was no change in the appearance of the left foot or leg. A left femoral arteriogram was performed and showed complete occlusion of the left superficial femoral artery and extensive arteriosclerosis of the popliteal artery and its branches. A left superficial femoral endarterectomy was performed but the pedal pulses remained absent.

Postoperatively the patient made a good recovery but the left leg and foot remained cool and painful. He was discharged three weeks after operation, only to be readmitted several days later because of increasing ischemia of the left leg. On February 25, 1959 a left mid-thigh amputation was performed. Although the patient did not complain of chest pain, an electrocardiogram taken postoperatively showed evidence of a recent myocardial infarction. He was treated medically with anticoagulants and bed rest. His rehabilitation was further delayed by the need to revise a painful amputation stump on July 28, 1959. He has since made excellent progress with a left lower extremity prosthesis. He has returned to work, regained his sexual potency, and is now without symptoms.

Comment

Complete restoration of blood flow by thromboendarterectomy is an effective method of treatment when the occlusive process is well localized to the distal aorta and proximal iliac arteries. This was clearly illustrated in the first two cases reported above. This procedure can be performed more rapidly than blood vessel grafting and has the further advantage of not requiring the use of a graft acting as a foreign body.

There is now general agreement that the result

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of any direct arterial surgery, grafting or endarterectomy, depends upon the extent to which the distal arterial bed is involved. When the exit flow or "run-off" is extensively compromised by disease and occlusion, results are poor. In the third case described above, aorto-iliac thrombo-endarterectomy successfully restored the circulation to the right lower extremity. However, in spite of the return of a good left femoral pulse, distal pre-existing occlusion of the femoral artery and its branches precluded good blood flow to the left leg and foot. The result, however, was considered satisfactory in view of the extent and severity of the patient's disease and his prognosis without definitive treatment.

SUMMARY

Arteriosclerotic occlusion of the distal aorta is a progressive, incapacitating disease which is amenable to surgical treatment in most cases. The diagnosis is readily made from the clinical manifestations of the disease, particularly if the condition is suspected and care is taken to include palpation of peripheral pulses in the physical examination. Restoration of vascular continuity and normal blood flow can be accomplished by either resection of the diseased aortic bifurcation with homograft or prosthetic replacement, or thrombo-endarterectomy. When the atheromatous process is well localized, endarterectomy has the advantage of requiring less operating time and avoiding the use of grafts which may act as foreign bodies. Success—or failure—of any surgical treatment depends upon the extent to which the vessels distal to the obstruction are involved in the occlusive process. Three cases are presented illustrating the clinical features of Leriche's Syndrome and surgical treatment by thrombo-endarterectomy.

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rials and workmen (also aged) about the area as needed. Even more gratifying was the obvious happiness of the majority of these people and their pride in their work. Their affection for Doctor Schadel was as obvious as was his affection for them.

Besides its able-bodied elderly inhabitants, Nwey Avoth houses about 250 who are infirm and require help in dressing, eating, and getting about and also 24 who require nursing. There are in Section A two full-time physicians and twelve practical nurses and a chief nurse who is a man and is registered. Three of the other nurses are male. Despite the fact that many patients have complete incontinence, their area was clean, and we were informed that no decubitus ulcers had occurred.

The buildings in which these people are housed are attractive, clean, and pleasant. Elderly couples are kept together, and single men and women are in three- or four-bed rooms with those of their own sex. In each of the houses there is one person assigned to the duty of checking up on all beds every day to note and report if anyone does not get up and go about his usual occupations. Kitchen, food distribution, equipment, and storage facilities appear up to hospital standards. The same food is served to all, including the senior physician who can judge its quality by what he receives. Under his supervision the weekly menus are planned and posted.

While the other twenty or more institutions of Malben vary in size, they are all conducted on the same principles. Aged individuals other than those who have come to Israel as immigrants and who have no insurance, relatives, or other means of obtaining assistance but are not eligible for Malben are relatively few and are the responsibility of the communities in which they live. The work of Malben, on the other hand, is independent of community resources. It deals with the large group of aged Jews many of whom have come to Israel after most or all of their families had been killed and all hope for their future had apparently been destroyed. The success of its work was very apparent to us in our visit to Nwey Avoth.

It is clear from this short summary that these elderly people who have come to pass their remaining years in the State of Israel, which has been established as a homeland for those of their faith, are being given not only kindness and, as far as possible, the fulfillment of their physical needs, but also real consideration for their happiness and their dignity as citizens and human beings.

GOLF TOURNAMENT
WEDNESDAY, SEPTEMBER 14

EXPERIENCES WITH A NEW PSYCHIC ENERGIZER

EDWIN DUNLOP, M.D.

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DURING THE last three years, a remarkable number of studies have been made with regard to a group of drugs known as psychic energizers, of which some are monoamine oxidase inhibitors while others are thymoleptic drugs. Both produce equivalent clinical results by stimulation of the central nervous system. Rationale and mechanism of action of this new class of psychopharmaceuticals have received broad attention. Imipramine hydrochloride (Tofrānil®) possesses an unique mode of action which has been studied regarding its use in all forms of depression. This report describes the results obtained with imipramine in 77 patients of whom some were on ambulatory treatment and others hospitalized.

This study was undertaken to determine whether mild to severe depressions could be managed with drugs alone, as well as to compare, or combine imipramine and electroshock therapy in patients who had previously been treated with the latter alone. Electroshock therapy has for over twenty years been regarded as the most effective treatment of depressions. Its present value as optimal therapy has been enhanced by the introduction of intravenous anesthesia and muscle relaxants. However, its classical position has been challenged by the introduction of iproniazid, a monoamine oxidase inhibitor, and later additions with enzymatic action.

Each patient in this series showed signs of depression. A diagnosis of depression was established, if the patient presented most of the following symptoms: despondency, apathy, fatigue, psychomotor retardation, insomnia, diurnal changes in mood, loss of weight and appetite, suicidal drive. All of our patients after study corresponded to one or another of the seven varieties of depression recognized by the American Psychiatric Association. The study was based on target symptoms rather than on differential diagnosis of the depression, indicating a need for psychic stimulation. Very early in our experience some extremely conflicting results were produced.

Case No. 1: This forty-eight-year-old man had three episodes of depression. In 1946 he was committed to a state hospital where he received thirty shock treatments and improved in about two and one-half months. In 1953 he had a recurrence of the same depression, accompanied then by delusional ideas regarding tremendous guilt feelings concerning his childhood, which required at that time electroshock treatments. In 1957 he again had an identical reaction in behavior and thinking. Response to eight shock treatments and daily administration of 200 mg. of chlorpromazine was favorable. On June 8, 1959 he was in the same condition as prior to treatment. He was depressed, withdrawn, felt that everyone was against him, had tremendous feelings of guilt regarding his childhood, and was desperately afraid of electroshock therapy. Administration of imipramine, 25 mg. four times per day orally, was initiated at once, 75 mg. were given immediately by intravenous injection, and 50 mg. were daily administered intramuscularly. Within three days we were able to note in his clinical record: "The patient has made an astonishing recovery that is truly amazing in comparison with his past illness which has often taken considerable time and has required many electroshock treatments. We believe this is due to the rapid action and mood-elevating effect of Tofrānil."®

Our observations were confirmed by results obtained in other cases.

Case No. 2: Sixty-two-year-old widow, whose diagnosis on April 22 revealed recurrent reactive depression of six weeks duration. This was her second recurrence requiring electroshock therapy. The patient manifested apprehension regarding electroshock treatment despite her overwhelming fear and guilt reactions. Her depression was marked, with insomnia, agitation, complete loss of interest in purposeful activities, and expression of suicidal drive. Within nine days the patient showed an excellent response. Moreover, two weeks later, she was placed on a maintenance dose of 25 mg. daily on which she remained for four weeks until her discharge, completely recovered.

Case No. 3: A sixty-seven-year-old man was referred to us at the request of the Department of

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Health, Education and Welfare to determine his eligibility for Social Security retirement benefits. Three years previously the patient had been acutely depressed and had been referred to us for electroshock treatment which had to be interrupted after six or eight treatments because of his fear of further electroconvulsive therapy. A week or two later the patient was committed to a state institution where he underwent the same experience. After three months he was discharged without improvement following his refusal to undergo further electroconvulsive therapy, and remained depressed and at home. We used this opportunity to administer imipramine, with little results during the first two weeks. However, within a month, the patient responded for the first time since the onset of his illness. He showed a weight gain of 12 pounds, and his usual congenial composure was restored. His apathy, listlessness, tension, crying spells, irritability, and generally depressed outlook had completely reversed, and he was, in fact, no longer interested in obtaining retirement benefits but in securing re-employment, since he felt fully capable of resuming his work, left three years ago.

With this encouraging experience, imipramine therapy was instituted in four other patients in whom "electroshock failures" had occurred, and again most excellent results were obtained in all four. One female patient, who had remained depressed for many months following a rather severe automobile accident, and who had numerous somatic complaints, gained 28 pounds of weight within 30 days on imipramine therapy, regaining simultaneously her usual drive and ambition. She was able to resume her normal activities, and her depressive symptoms disappeared steadily and progressively. Following the institution of a maintenance dose of 25 mg. per day, she continued to improve.

In 22 patients out of 77, electroshocks in moderate numbers had formerly been required to obtain complete remission. In all of them it was noticeable that results equaled those of previous treatments. However, many fewer electroshock treatments were required when imipramine was concomitantly administered. In no way did imipramine affect routine administration of barbiturates, muscle relaxants or the accepted technique of electroshock therapy, or cause an undue potentiation of sedation. In many instances the barbiturates were used for sedation, and tranquilizing drugs of both the meprobamate and the phenothiazine groups for control of anxiety or agitation.

Method

Imipramine was administered in dosage of 25 mg. four times per day, and this dosage was decreased to as low as 25 mg. per day after remission of symptoms and stabilization had occurred. In the early stages of treatment, a fast-acting, mood-elevating drug, such as amphetamine, was administered to some of the patients. Adjunctive therapeutic measures were not incompatible with imipramine, but were administered to eliminate the "lag period" which is often observed prior to clinical improvement.

Number of Patients: 77

Age	*Male*	*Female*	*Total*
Under 15			
15-24			
25-34	4	7	11
35-44	7	15	22
45-54	10	7	17
55-64	6	10	16
65+	2	7	9
Unspec.	2		2
Total:	31	46	77

Results

Judged by our criteria of social response, 77 per cent of the patients experienced complete recovery. Twenty-two of them had previously been on electroshock therapy, and in each case, by using imipramine simultaneously with electroshocks, their total recovery required many fewer treatments. Most gratifying results occurred in a number of patients who had had repeated electroshock therapy (some unsuccessfully), but who evidenced dramatic recovery when on imipramine alone.

Over-all Response	*Total*	*Mild*	*Severe*
Worse	1		1
None	2		2
Slight remission	6	4	2
Marked remission	19	6	13
Complete remission	49	14	35
Total:	77		

Signs of clinical improvement were frequently noticeable before the patient was aware of them. This, however, was not associated with any degree of overstimulation, excitability or manic behavior. On the average, the changes were rather subtle in their appearance, but certainly, within seven to ten days, demonstrable to patient and clinician. A good recovery was noticeable when appetite and weight were increased, the gains in weight frequently ranging from 5 to 10 pounds within two weeks. This type of weight gain appeared, however, to be different from that which is at times observed when drugs of the monoamine oxidase inhibitor group are administered associated in some instances with the formation of edema. Administration of imipramine apparently produced a nutritional improvement without provoking fluid reten-

tion. Other observers have noticed in patients an increase of energy, outgoing nature of activity, obvious cheerfulness, and renewed zest in resuming normal activities.

Side-effects

There was no noticeable evidence of toxic effects on liver, blood or kidneys. The eosinophile count revealed frequent paradoxical responses, one half of the patients showing a slight increase in eosinophiles, the other half a decrease or no change at all. Apparently, imipramine was rather well tolerated. Our oldest patient, an eighty-two-year-old female, and another a seventy-two-year-old patient, complained of agitation which subsided when the daily dosage was reduced from 100 to 50 mg. There were no reactions in any of our patients severe enough to require discontinuation of therapy, although dosage had to be reduced in some of them.

Frequent complaints were made concerning excessive perspiration, especially of the head and neck. However, such manifestations coincided with the warmest and most humid summer weather experienced in many years. An atropine-like effect, dryness of the mouth, was a fairly constant side-effect. But euphoria and overstimulation, so frequently occurring with amphetamine therapy, were not observed. In three children with the hyperkinetic syndrome,* Imipramine did not appear to be of any value, whereas treatment with amphetamine proved to be successful. This may further substantiate the impression that imipramine is not stimulating to the central nervous system but rather derives its beneficial action from a selective process. Jaundice, sudden falling, or impotence did not occur. Two patients reported delayed micturation.

Side Effects	*Total*	*Reg. Reduction*
Agitation	5	1
Hypomaniac	10	
Hallucinations	2	
Intensification of Del.	1	
Parkinsonism		
Akinesia	1	
Akathisia	6	
Dystonia	1	
Syncope	9	
Hypotension	12	
Palpitation	20	
Cardiovascular	1	
Tremor	5	
Diplopia	1	
Perspiration	27	
Dry Mucous Membranes	10	
Jaundice	0	
Photosensitization	0	
Dermatologic	2	
Constipation	14	1
Excessive weight gain	12	5
Urinary frequency	7	
Nausea	2	
Dizziness	6	
Falls	0	

Diagnosis	*Total*	*Mild*	*Severe*
Periodic Depr.	19	7	12
Involution Depr.	17	8	9
Manic-Depression	5	2	3
Reactive Depr.	14	5	9
Organic Depr.	2	2	
Puerperal Depr.	5	3	2
Psychoneur. Depr.	5	4	1
Senile Depr.	6	3	3
Schizo-Affec. Depr.	2	2	
Unspecified Depr.			
Schizophrenia	1		1
Alcoholism	1		1
Other			
Total:	77		
With Agitation			

Discussion

Imipramine (Tofrãnil®) should not be confounded with tranquilizers, nor is its mode of action that of monoamine oxidase inhibition. It relieves the depressive condition but does not act as a stimulant to the point of excitation. Its mode of action is apparently rather a corrective one, directed on the underlying physiologic cerebral disturbances, and it is remarkably free from any excitation. Improvement of the patient is noticeable not only with regard to relief from the target symptoms of the depression, but also in physical strength, well-being and nutrition.

Of particular interest in this group of 77, were the patients who had previously required electroshock therapy. In 22 of them, no electroshock treatment has been necessary since administration of imipramine was instituted. In patients to whom, because of the severity of their depression and the presumed suicidal risk, electroshock treatment was given from the onset of therapy and imipramine administered simultaneously, a substantial decrease in the number of electroconvulsive treatments was possible.

In one patient, requiring ten electroshock treatments in 1957 and twelve in 1959 without any noticeable improvement, electroconvulsive therapy was discontinued and imipramine given alone for

*Not included in this study.

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ten days, with a very gratifying and conclusive result. Imipramine is particularly useful when the drug is administered during hospital treatment which may include electroshock or psychotherapy. Concomitant administration of imipramine and physical treatment represent a broader working base for patient and therapist.

Institution of a maintenance dose of imipramine as was our practice, also facilitates psychotherapy. First of all, imipramine apparently makes the patient more accessible to psychotherapy. Secondly, supervision of the medication during the recovery period gives the psychiatrist opportunity to follow the patient's course to a successful conclusion, whereas a patient's treatment terminates following clinical improvement from electroshock.

It is well recognized that, associated in the dramatic response produced by electroshock, some confusion may result, and that a patient who is confused following shock treatment is never a good candidate for psychotherapy. Aftercare now becomes much easier, since the patient no longer anticipates a treatment each time he has to see his therapist, but knows he will continue on psychotherapy while the drug is continued.

In all patients wtih a depression and a history of recurrence within a period of twelve months, administration of imipramine is maintained after their discharge to avoid a possible recurrence.

LERICHE'S SYNDROME

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DID YOU KNOW?

- **That adults over the age of 25 average almost twice as many days of restricted activity from illness or injury as persons under age 25.**
- **That in a 12-month period, about 23 million persons under age 25 received injuries severe enough to require medical attention or restrict activity.**
- **That four out of every 100 children under the age of four has a chronic or permanent health impairment, compared to eight out of 100 between the ages of 15 and 24.**
- **That children under age four see a physician more than six times a year on the average, while children from ages 5 to 14 are visited by physicians about four times a year.**

CHANGING TIMES AND THE CHALLENGE TO HEALTH*

FRANCIS H. HORN, PH.D.

The Author. *Francis H. Horn, Ph.D., of Kingston, Rhode Island. President, University of Rhode Island.*

AS ONE WHO has spent all his life in education including a number of years at one of the world's great medical institutions, Johns Hopkins, I have had over the years considerable interest in health education and professional preparation for the health fields. But my comments are those of a layman, a layman extremely interested in your work, true, but one who may indeed reveal a layman's ignorance of your very complex problems. It may be useful, however—I certainly hope that it is—to have a layman's viewpoint on the theme of your conference—*Changing Times and the Challenge to Health.*

The academic man is prone to begin with definitions. The dictionary defines "health" as "State of being hale or sound in body, mind, or soul; especially, freedom from physical disease or pain." At the risk of stating the obvious, I want to emphasize the importance of mental health in any appraisal of the challenge to health. With about half our hospital cases mental patients, to neglect consideration of mental health is to overlook one of the major challenges to the health professions. The changes I foresee in our future mode of life will, I believe, add greatly to the already overwhelming problems of dealing with the mentally ill. They will, moreover, make further research into the area of psychosomatic medicine of ever greater importance.

With this introduction, let me now examine the present situation regarding health, suggest some of the changes society and the world are undergoing, and attempt to set forth the implications for health of these changing conditions.

My first observation is to pay tribute to the remarkable progress that medical and pharmaceutical science has made in recent years. Consider the advances in preventive medicine, for example, highlighted in our day by the discovery of the Salk vaccine for polio. Or the remarkable development of antibiotics, with several hundred such drugs today whereas less than twenty years ago there was only penicillin. Or the achievements in surgery, by which delicate operations undreamed of a generation ago have been successfully performed. And yet, remarkable as the progress thus far has been in alleviating pain, stamping out disease, and prolonging human life, still more remarkable achievements lie ahead. Somewhere before long doctors and scientists will discover how to lick the last of our great killers—diseases of the heart and blood vessels, our number one killer, currently taking a million American lives a year; cancer, the second killer; and the others, arthritis and rheumatism, and diseases of the nervous system. The rarer, but no less deadly diseases, will also eventually be overcome.

It is imperative, of course, that if the challenge to health still posed by these diseases is to be met successfully, there must be continuing research of substantial magnitude. Improving health in this country and throughout the world depends upon constantly increasing knowledge of the mind and body. This comes primarily through research. Fortunately, in my opinion, the federal government is now putting substantial amounts for research into the health fields. For a good deal of this, we can thank Rhode Island Congressman John E. Fogarty, who has done so much to awaken the nation and his colleagues in the Congress to the importance of supporting better health. He has, as a matter of fact, been hailed on the floor of the House of Representatives as the "Champion of better health for the nation." Under his prodding, in a dozen years the appropriation for the National Institutes of Health has risen from 3½ to 241 million dollars. Still more support is needed. Large as it is, federal support of better health is little indeed when compared to the more than 40 billion dollars we spend annually on the military establishment.

This increasing federal support of research in the health fields poses a question for the voluntary health agencies. Until recently, most of the advances in defeating disease resulted from research supported by nongovernmental sources. Today these advances represent a partnership of both public and private agencies. As more federal money becomes available, however, support of voluntary agencies may well be questioned by overburdened taxpayers, and may decrease to such a point that

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*An address delivered at the Twenty-fifth New England Health Institute, at Providence, Rhode Island, June 17, 1959.

continuance of such agencies will be difficult if not impossible. But, regardless of the sponsorship of research, it is certain, I believe, that the future will bring continually increasing research in the health fields, with comparable benefits to mankind through better health.

Outstanding Results of Health Research

The results of past health research are everywhere evident. It is clear that the advances medicine and pharmacy have made have resulted in greater preservation of life at all levels, from infancy to old age. Two of the major characteristics of our rapidly changing times are the longer life span and the greatly increasing number of people. The average life span in the last half century has increased from 48 to 67 years for men, from 51 to 73 for women. Unquestionably, this will continue to rise. In the space of a generation, it may become quite normal to live to be a hundred.

Lowered mortality and living longer have combined with an increasing birth rate to produce substantial population growth. It is difficult to know what the future population will be. The demographers are always revising their estimate upwards. Two years ago the Scripps Foundation for Research in Population forecast a population of 228,000,000 in the United States by 1975. Today it is 175,000,000. The Foundation predicted at that time a world population by the year 2000 of 4 to 4½ billion compared to the present 2,700,000,000. But a United Nations report a year later predicted 6 billion and a still later one indicated it might reach 7 billion.

Regardless of the precise numbers, certain implications seem clear. These changes in our society resulting from constantly improving health services pose several significant challenges.

First, is the fact that we shall have substantially greater proportions of our population who are children and those who are past the biblical span of three score years and ten. The major problem, healthwise, is with the aging and aged. Increasingly our senior citizens will be in possession of their mental and physical powers, but eventually deterioration must set in. With their numbers increasing so rapidly and their life being prolonged into the eighties, the nineties, and even over the century mark, the problems of providing health care will multiply. Recognition of these problems is evidenced by the establishment at the national level of the Joint Council to Improve the Health Care of the Aged.

Second, not only the older elements of our population but all age levels, will require more medical attention and health services. We have been increasingly conditioned to the necessity of "seeing the doctor." Many a mother rushes her child to the physician when he has the sniffles; a generation ago, she would have done her own doctoring. From car cards and billboards, magazine and newspaper advertisements, radio and TV announcements, we are warned that if cancer doesn't get us, heart disease will, and we are urged to see our physician.

New wonder drugs are forced on our attention with greater insistence than ever before. Shots of all kinds are standard procedure for most families. Hospital and medical service coverage are carried increasingly by regularly employed persons, and are becoming a fringe benefit for more and more of them. Insurance against major medical disasters is becoming more common. Our health is never very far from our thoughts and the doctor and the hospital are always just around the corner.

All this means that in the future, despite our continual progress in medical service, demands for health services of all kinds will constantly expand. To serve the health needs of an ever enlarging population, persuaded by all the techniques of modern advertising of the importance of health care, will require tremendous increases in health personnel and facilities. One of the major challenges of the future will be providing adequate numbers of physicians, surgeons, psychiatrists, dentists, nurses, pharmacists, dietitians, physical therapists, medical and dental technicians, and other specialists concerned with the maintenance and improvement of health. Similarly, there will be a real problem in providing the required clinical, laboratory, and hospital facilities.

Cost Problem a Major Issue

Answers will also have to be found to the problem of the costs of health services—both to the individual and to society. The matter is acute in terms of the charges for medical service. President Eisenhower recently appealed to the National Convention of the American Medical Association to hold the line on fees. If the problem is not solved to the satisfaction of the ordinary citizen, so that adequate medical and hospital services are available to him and his family at a price he can afford, at least with voluntary health insurance, then, in my opinion, he will see that he enjoys these benefits through some form of government-subsidized health care. "Socialized medicine" is a hateful term to most members of the medical profession. But if the profession does not find the way to provide the increasing medical care that an ever expanding population, more and more conditioned to the necessity of such care, demands, "socialized medicine" may become a reality.

The other aspect of this problem is the cost of health services, not to the individual, but to society. Medical treatment is more and more expensive. Institutionalized care these days is seldom covered

by the payments of the patient, high as these are. In addition, with an increasing load of welfare cases of one sort or another, the drain on the fiscal resources of local communities and states is staggering. Some means of meeting the problem must surely be found.

Thus far I have been discussing some of the problems that individuals, the health professions, and government are facing because of the extraordinary success of the health sciences. It is paradoxical, but true, that the more successful these sciences are in overcoming disease, the greater the demand for health services becomes. It is true also that the remarkable progress in health services has resulted in improving the health of the nation. But changes occurring in our day, and the still greater changes that will come in the future, may well offset the advances that have been made in overcoming pain and combatting disease. Let me now suggest some of these changes and the challenge they pose for health.

Changes Pose New Challenges

Modern technology has produced a new tempo of life. For one thing life has speeded up. One always seems to be rushing around. Part of this effect results from the increasing speed of all forms of transportation. Autos, boats, airplanes—all go faster and faster. Air speeds of as much as 5,000 miles an hour are being predicted. We are studying the physiological effects of these increased speeds. They may produce new health problems, we don't know yet. But of one thing we can be pretty certain. Higher speeds, along with vastly increased numbers of vehicles as the population expands and our higher standard of living permits more vehicles per family, will result in more accidents, many fatal, of course, but most resulting in injury of one sort or another. Ponder the potential for accidents when vastly larger numbers of people learn to fly and operate their own airplanes. The growing popularity of boating of all kinds is proving a greater accident hazard. The medical profession may well lick the last major diseases, but it will surely face new and growing challenges in the areas of physical rehabilitation and plastic surgery.

New challenges to health are likewise to result from man's probing to the depths of the sea and to the outer reaches of space. It is unlikely that there will be extensive interplanetary travel in the future, but who can tell? For some time to come, assuredly, this new challenge to health will effect the few, not the many.

But improved technology, especially the spread of automation, will create new health problems for large numbers of people. Undoubtedly, there will be less physical fatigue, but probably other kinds of fatigue will become more widespread. The almost constant noise in which individuals live certainly contributes to mental fatigue. The increase in leisure and the inability of many to know how to enjoy it may create or aggravate health problems. Intensification of weekend athletics and recreation for those not in good condition for such activities will certainly add to the amount of health problems, though it may not create any new ones.

Certain other conditions of modern life, and they may be intensified in the future, contribute to the challenge of health. There are the often overpowering uncertainties of life with the consequent search for security. With one out of three marriages ending in separation or divorce, broken homes add to contemporary health problems. The cold war and the threat of annihilation contribute to the general uncertainty, above all to a prevailing sense that man no longer has any control over his destiny, that he is the prey of forces over which he has no control.

These and similar conditions of our time, and the future seems to promise an aggravation of such conditions, produce all sorts of tensions and frustrations, resulting in psychosomatic troubles, alcoholism, nervous breakdowns, and suicide. Today, more and more individuals depend on drugs to get them through the day. Some need "pep pills," others, tranquilizers. It is not uncommon for the same person to need an energizer to get going in the morning and a sleeping pill to get to rest at night. I have already indicated the great extent of our mental diseases. Meeting the problems of mental disease may well be the major challenge to health as we enter the new age that lies ahead of us.

Let me now suggest briefly several other changes that this age will bring that will challenge health and increase health problems. Many of them spring from scientific research and technological progress. So great are these changes likely to be that one great scientist has posed the question, "Can we survive technology?"

There is, of course, the ever-present danger of another world war, with the possibility of the annihilation of mankind. Even if mankind were to survive a modern war, the problem of restoring the survivors to health would be staggering. However, I am optimistic and do not expect such a war to develop. But preparation for the eventuality of war is currently challenging the health advances man has made over the years. The problem of radioactive fallout from the testing of nuclear weapons is certainly the most arresting of the health problems. The controversy among scientists as to the extent of the danger makes it difficult for the layman to appraise the seriousness of the problem. But certainly it is a serious one.

The problem of atomic waste and its disposal is another. As peacetime uses of atomic energy in-

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crease, this health problem becomes more acute. It will require closer working relationships between the medical experts and the sanitary engineers.

In another area, that of nutrition, science is making discoveries that may challenge health. We are discovering new sources of food and new methods of food processing. Chemistry is being used increasingly to modify the nature of the things we eat. Several papers at this meeting will consider the problem of additives. As science increasingly modifies the nature of our food, the protection of health will require constant testing of results and strict control of the processes. And who knows what may eventually result from the continued application of science to food? For years we have joked about eating only pills. I hope the day never comes, but it may. Likewise, scientific experimentation—some would call it tampering—in other areas may produce new challenges to health. There is, for example, the matter of weather and climate control. Other possibilities of manipulation of "normal" or "natural" processes will develop in the future. Increasing control of the individual environmental factors of life seems inevitable. Any increase in this matter has implications for health.

Also important in challenging health in the future are certain cultural and sociological environmental factors. Let me just mention several. One is the increasing percentage of married women in the labor force. Some 60% of working women also are responsible for homes. Another is the increasing mobility of our people. One out of every three families moves every two years. There are health problems, more serious than just the sanitary ones, in the increasing number of people who live in "mobile homes." The number of Americans living abroad, often in Asia and Africa, is growing rapidly. Including the military, there are now over two million. The health conditions some of them face pose new problems. Other modifications in our traditional way of life could be cited.

Urbanization a Factor

Let me mention one more environmental factor that has a major challenge to those in the health fields—the growing urbanization of the country. I believe there is still some doubt whether the process will result in further deterioration of our cities or provide the incentive to make them healthier and happier places in which to live and work. The race is still between creeping slums and urban renewal. We have the technical know-how to win the race; whether we have the will to do so and are ready to pay the cost, remains to be seen. Perhaps no aspect of our changing times presents a greater challenge to health than this problem of providing healthier environment in our metropolitan areas.

I think I have outlined enough of the problems that those in the health professions must be facing in the coming years. I am sure you all are aware of them, although I suspect that knowing how to lick them is another matter. I should like to conclude these remarks with a few observations appropriate to an educator.

First, let me repeat my statement about the increasing demand for people in the health professions. The universities are not turning out enough graduates in these fields to keep pace with the increasing population. Means must be found to stimulate more young people to prepare for service in the health field. And with the increasingly complex problems that those on the health team must face, their professional training must be constantly improved. At the same time, it should be obvious that specialized training is not enough. The worker in the health field requires an increasingly broad background of knowledge bearing upon both the individual and collective environment. The health professions have recognized this and are stressing the importance of liberal education accompanying the scientific and professional training. Pharmacy is the latest to move in this direction, for beginning in 1960, all accredited schools of pharmacy go on a five-year program instead of the present four-year program. With knowledge of all kinds expanding so rapidly, it will become increasingly difficult to provide the necessary education and training in the years that can be given to it in school and college. But constant study as to how it can best be done is required if we are to provide the practitioners in the health professions needed by our changing society.

In addition, it should be clear, continuing education, of both a general and professional nature, is a must for such practitioners. Colleges and universities need to work with the professions in providing opportunities for appropriate continuing education.

Second, let me emphasize that the need for good health is greater than ever before. The need for robust physical health may not be so great as it was when we were carving a new nation out of the wilderness or pushing the frontier across the continent. But never before was good health in all its aspects so important. In these precarious and uncertain times, in which, indeed, the future of mankind hangs in the balance, with life speeded up on every hand so that critical decisions often have to be made in a split second, and with the increasing complicity of the problems facing a shrinking world, the individual requires sound health. We must have cool heads and collected emotions, difficult indeed to have if the individual does not enjoy good mental and physical health. The old Greek ideal of a "sound mind in a sound body" is even more relevant for our time.

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Editorials

INTEGRATION OF THE ARTS AND SCIENCES WITH MEDICINE

THE Johns Hopkins University has embarked upon a revised program of medical education. As described in outline by Thomas B. Turner, M.D., dean of the medical faculty,* the program attempts to correct what the Hopkins authorities regard as three undesirable trends in contemporary medical education. These undesirable trends are first, the increasing length of time required to reach a productive stage in practice or research; second, the sharp break with the humanities when the student enters the medical school, and often before; and third, the relative inflexibility of the medical curriculum, and in particular the lack of opportunity to engage in one of the most valuable of all educational experiences, that of research.

In an effort to counter this trend toward a pattern of premedical and medical education which is impoverished in respect to the humanities and the social sciences, the Johns Hopkins Medical School is undertaking what is in effect an experiment directed toward healing the schism. The medical course at Johns Hopkins will now consist of five years instead of the traditional four; these will be designated Years I, II, III, IV and V.

Students admitted to Year I will be registered for courses given by both the medical faculty and by the faculty of philosophy of the University. Prerequisites include one year of college biology and college chemistry, two years of one foreign language and mathematics at least through analytical geometry. In addition there are definite prerequisites in the humanities and social sciences to the extent that at least one half of the student's time of the first two years of college must have been devoted to subjects within these broad fields although individual subjects are not specifically designated.

In Year II of the Medical School course the student will divide his time about equally between the sciences and the humanities. Courses in chemistry and mathematics will be given by the appropriate departments of the Medical School, while a rich assortment of courses in the humanities and the social sciences and a basic course in physics will be offered by the faculty of philosophy.

*Federation Bulletin—Federation of State Medical Boards of the United States, July 1959.

The class of Year II, which is analogous to the traditional first year of medicine, will comprise both students who reach it through Year I and college graduates who are admitted directly to Year II. Instructions for all students in this year will contain required work in the history and philosophy of science, which may be regarded as a bridge between the humanities and the sciences; and in the social sciences and medical psychology. In the former development, the department of the history of medicine, which is organized on a full-time basis, will play the key role. Students who enter through Year I must qualify for the A.B. degree at Johns Hopkins before being allowed to proceed with the medical course.

The foregoing is a brief outline of the formal course work related to the attempted integration of medicine and the humanities. According to Doctor Turner, it is hoped that the spirit of this integration will permeate both the faculty and the student body—the spirit so well exemplified by Osler and Welch during the early years of the Johns Hopkins Medical School when much of their thought and energy were devoted to preserving this balance between the great areas of learning. Informal talks and seminars are being held in the Medical Residence Hall by individuals in fields other than medicine, such as politics, the arts and history. Likewise, a lectureship has been established in the School of Medicine devoted to one or another aspect of the interplay between the humanities or the social sciences and medicine.

In the Johns Hopkins Medical School it is recognized that the four or five years of medical school are but one segment of the educational process for making an intelligent and competent physician; much goes before and much comes after this period. Medical educators must try to see the picture whole, to the end that medical education does not become isolated from the main stream of man's intellectual venture down the corridors of time.

FUNGUS OR NO FUNGUS

Recently we received from one of our dermatologists an interesting account of his experiences with patients which illustrates yet once again how

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easy it is for *homo sapiens* to live on occasion in the friendliest symbiosis with another *homo*, whom H. L. Mencken called, a little cynically, *homo boobiens.*

The doctor writes as follows: "Several vigorous complaints have been heard recently of considerable expense incurred by the purchase of the new antifungal wonder drugs for the treatment of fungus of the nails without any benefit whatever. But how was the diagnosis of 'fungus' of the nails made? Merely by looking at some deformities or abnormalities of said nails. The reason for the failure of the wonder drug to effect a cure was that most likely there was no fungus but rather psoriasis or any other condition you may care to name.

"Fungus of the nails (onychomycosis) as well as fungus of the skin (dermatomycosis) or of the deeper structures (deep mycoses) cannot be diagnosed by sight. The pathogenic organism must be demonstrated under the microscope and by culture. Without this procedure the diagnosis of 'fungus' is of no value whatsoever and the antifungal treatment quite uncalled for and therefore useless. The indiscriminate use of the drug will be of real benefit only to manufacturers and distributors. The ancient admonition to do the patient no harm should always include solicitude for the protection of his purse."

SESQUICENTENNIAL OF THE YALE SCHOOL OF MEDICINE

On October 28 and 29, 1960, the Yale School of Medicine will celebrate a century and a half of its existence. The occasion will be marked by meetings, exhibitions and appropriate addresses. Among a group of notable guest speakers will be Sir Howard Florey of Oxford, England. Complete details of the program will be announced later.

It was in October, 1810 that the Connecticut General Assembly granted a charter to Yale College for the establishment of the Medical Institution of Yale College; and so the fifth medical school in the United States came into being. Unlike its predecessors the medical school was founded through impetus coming chiefly from within the College and not from a group of outside physicians.

The first medical faculty at Yale was a notable one, embracing Eneas Munson, foremost authority on materia medica, Nathan Smith and Benjamin Silliman, still counted among Yale's greatest, Eli Ives and Jonathan Knight, leaders in medicine, both of whom became presidents of the American Medical Association. From the birth of the school the Connecticut Medical Society was a partner in the enterprise and contributed much to its welfare during the first half of the School's existence.

Other events associated with the sesquicentennial celebration will take place during the academic year 1960-61. These include an exhibition of medical art at the Yale Art Museum and a scientific meeting to be held in conjunction with the dedication of a new Medical School auditorium.

CHANGING TIMES AND THE CHALLENGE TO HEALTH

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School Health Education Needed

To help produce this ideal more widely, I am convinced that we need a more effective program of health education in our schools and colleges. Today I have spoken largely of the challenge to health from the standpoint of meeting the new conditions of ill health, both mental and physical, imposed by our changing times. But a major aspect of the problem remains education, so that the assistance of the health professions is reduced to a minimum. An effective program of health education—in which I include what we now refer to as "physical education"—is essential in creating the conditions in today's and tomorrow's society by which the individual can live a healthier and consequently, happier and more satisfying life. I am not going to suggest today the nature of the program; indeed, I am not competent to do so. I wish merely to point out the importance of the matter and to suggest that greater co-operation is needed on the part of educators and the health people if the most effective results are to be realized.

And now, one final comment. I have been discussing the challenge to health in our own country, realizing, of course, that any advances on the health front here will benefit people everywhere. But increasingly the benefits of good health have to be made available to all peoples throughout the world. Unless the world as a whole in some measure approaches the standards of health and living that we enjoy in the Western democracies, the world will continue to be one of tensions and uncertainties, with war as a possibility. In such a world, good health is more difficult of attainment than in a world generally at peace. Redoubled efforts must be made, therefore, to bring to people everywhere the health benefits that we in more privileged countries enjoy. This world-wide challenge to health is perhaps the greatest opportunity that today is open to workers in the health fields.

GOLF TOURNAMENT

Wednesday, September 14

Providence Medical Association

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

U. S. Civil Service Commission Announcement of New Voluntary Health Insurance Plan to go into Effect on July 1, 1960

APPROXIMATELY 1,800,000 Federal employees are expected to enroll in the new health benefits program for themselves and more than 2,200,000 dependents under one or another of the plans offered. The enrollment period will be June 1 through June 30. Most of the participating plans will offer a high and low option of benefits, each with premiums related to the value of the benefits offered.

The huge enrollment expected and the wide variety of choice of plans and options offered make this program the largest and most complex employer-sponsored voluntary program of health benefits in the world, the Commission said. The Government will contribute to the cost of each health benefits plan, with the employee paying the balance of the cost of the plan he chooses through payroll deductions. The volume of first-year premiums is expected to approximate $250,000,000.

For an employee who enrolls for self only, the Government contribution will be $2.82 a month. For self and family enrollment, the government will pay $6.76 a month, except that if the covered family of a female employee includes a nondependent husband, the government contribution will be $3.94 a month.

While following, in many respects, traditional patterns set by other large employers, in some respects the two government-wide plans set precedents. Major advantages which are not generally found in the plans of large employers but which will be provided for Federal employees are:

Each employee will have a free choice among a variety of plans and options.

The cost to employees is guaranteed for a contract period of 16 months, even though hospital and medical costs continue to rise.

Employees who retire on immediate annuity after the program goes into effect may retain coverage for themselves and dependents with no reduction of benefits and at the same cost to them as for active employees. This factor will increase in importance in future years.

Coverage of dependents, again at the same rate, may continue after the death of an enrolled employee or annuitant.

No waiting periods are required for maternity benefits and no exclusion from coverage on the basis of pre-existing physical or mental conditions or age is permitted.

Employees in a nonpay status are covered for up to 365 days without contribution by the government or the employee.

In cases where an employee leaves Federal service for reasons other than retirement, a 31-day extension of coverage is provided at no cost to the employee or the government in order to give the employee, or his surviving enrolled dependents, an opportunity to convert from group coverage without medical examination to an individual contract.

A person confined in a hospital on the 31st day of continuance of coverage is entitled to benefits for up to 60 days more.

Indemnity Program by Insurance Industry

The government-wide indemnity plan is offered by the insurance industry. It will be administered by Aetna as the prime carrier. It will be underwritten by Aetna and all other companies in the group health insurance field who desire to participate in the health benefit program through reinsurance.

The plan will offer benefits covering first-dollar costs of hospital room and board. After payment of a $50 deductible, it will cover the majority of other hospital, and surgical and medical expenses, including the services of physicians outside as well as inside the hospital. The benefits will range upward to cover the heavy hospital, medical, and surgical expenses of costly illnesses.

The high option of this plan has a maximum benefit of $30,000 for each person covered. It also provides automatic reinstatement of up to $1,000 each year, and total reinstatement upon evidence of insurability. The low option of this plan covers similar costs but to a lesser degree. It has a maximum benefit of $10,000 per person and automatic reinstatement of up to $500 a year.

Blue Cross–Blue Shield Provide Service Plan

The government-wide service benefit plan offered by Blue Cross–Blue Shield will also include two options patterned after their hospital-surgical plans available in most localities, but with added

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GOVERNMENT-WIDE INDEMNITY BENEFIT PLAN

Under the Federal Employees' Health Benefits Act (to be offered by the insurance industry)

Kinds of Expenses	High Option	Low Option
Hospital Room and Board	PLAN PAYS First $1,000 each calendar year 80% of any charge over that amount YOU PAY 20% of any charge over $1,000	PLAN PAYS First $250 each calendar year 75% of any charge over that amount YOU PAY 25% of any charge over $250
Other Hospital, Surgical, and Medical	PLAN PAYS 80% of charges over first $50 YOU PAY First $50 each calendar year (the Deductible) 20% of Remainder	PLAN PAYS 75% of charges over first $50 YOU PAY First $50 each calendar year (the Deductible) 25% of Remainder
Maternity	PLAN PAYS Hospital — up to $15 a day for 10 days Obstetrician — up to $90 for normal delivery, $150 for Caesarean, $60 for miscarriage Anesthetist — up to $18 for normal delivery, $30 for Caesarean, $12 for miscarriage YOU PAY The remainder	PLAN PAYS Hospital — up to $10 a day for 10 days Obstetrician — up to $60 for normal delivery, $100 for Caesarean, $40 for miscarriage Anesthetist — up to $12 for normal delivery, $20 for Caesarean, $8 for miscarriage YOU PAY The remainder
Maximum Benefit	$30,000	$10,000
Monthly Rates	*Govt.* / *Emp.* / *Total* Self Only . . . . . $ 2.82 / $ 3.94 / $ 6.76 Family . . . . . 6.76 / 10.70 / 17.46 Female with non-dependent husband . 3.94 / 13.52 / 17.46	*Govt.* / *Emp.* / *Total* . . . . . $ 2.32 / $ 2.82 / $ 5.64 . . . . . 6.76 / 6.76 / 13.52 . . . . . 3.94 / 9.58 / 13.52

FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

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supplemental benefits provided after the payment of a corridor deductible for hospital, medical, and surgical expenses of costly illnesses.

The high option of the service benefit plan will offer basic benefits beginning with the first dollar of hospital expense, and basic surgical and in-hospital medical expense under fee schedules. Supplemental benefits, after payment of a corridor deductible of $100, will have a lifetime maximum of $20,000 for each person covered, with a provision for total reinstatement upon evidence of insurability.

The low option of the Blue Cross–Blue Shield plan is similar in pattern but with lower basic benefits, a corridor deductible of $200, and a lifetime maximum of $5,000 per person for supplemental benefits.

Both government-wide plans will be experience-rated. Each carrier must keep accounts for the plan completely separated from the accounts of other plans he carries. The carrier guarantees to pay all benefits under the plan, all taxes applicable to the contract, and all its expenses of administering the contract. For any year in which the amount received in premiums is less than the total cost of benefits, taxes, and administrative expenses, the carrier suffers a loss. As a fee for assuming this risk of loss, the carrier is allowed a fixed risk charge, payable only when experience is favorable. This risk charge, fixed in advance, is the only item of potential profit to the carrier.

In the Aetna contract, the risk charge will be 1.3 per cent of premium, automatically reduced to 1 per cent at the beginning of the first contract year after the plan has built up a special reserve equal to one month's premium. In the Blue Cross–Blue Shield contract, the risk charge will be 1.5 per cent of premium, with no provision for automatic reduction.

In both contracts, the amount allowed for taxes will be the actual amount the carrier is required to pay. Actual expenses not to exceed 5.5 per cent of premium, will be allowed. The reinsurers of the Aetna contract will receive two tenths of one per cent of premium as an expense allowance.

The first contract period will run from July 1, 1960, to October 31, 1961. At the end of the first contract period, and after each subsequent contract year, each carrier will prepare an accounting statement. If the total of accrued claim charges, taxes, and allowable expenses is less than the accrued premiums, the carrier will retain his fixed risk charge and credit any remainder to a special earmarked reserve for the Federal plan he carries. This special reserve, and income from investing it, will belong to the Federal Health Benefits Fund, and can be used only for payments under the plan which built it up.

Premiums for all years after the first contract period will be based on the actual experience of each plan. No plan will be expected to operate at rates which are too low to support the level of benefits provided. However, any rate which experience shows is too high for the benefit level of the plan will be reduced, or benefits will be increased. Any excess premium for a particular year is added to the special reserve.

All carriers will be subject to audit by the Commission and the General Accounting Office to assure compliance with the law and regulations, and to assure accuracy in accounting for funds.

Unusual Factors Cited by Actuarial Expert

Before approving these plans, the Commission consulted with the Federal Employees Health Benefits Advisory Committee established by the Health Benefits Act, and an interagency advisory committee of government personnel directors. In addition, it retained Milliman and Robertson, Inc., a nationally recognized firm of consulting actuaries of Seattle, Washington, to submit a report based on an impartial and independent study of both plans.

Mr. Wendell Milliman, president of the firm, in an oral briefing in advance of submission of his written report, advised the Commission that both plans meet the requirements of the Act. He found that the rates charged "reasonably and equitably reflect the cost of the benefits provided" and are "consistent with the lowest schedule of basic rates generally charged for new group health plans issued to large employers," as the Act requires. In his briefing to the Commission, he pointed out a number of factors present in the Federal Employees Health Benefits Program which are unusual and which had to be considered in fixing the rates to be charged. In addition to the special advantages offered, such as coverage after retirement, no waiting periods, etc., he noted:

> The choice available to employees, both in multiplicity of plans, and in option as to level of benefits, may result in some of the plans or options receiving a disproportionate share of employees and dependents who anticipate an above-average cost for their health care.
>
> Since the premium rates for the government-wide plans are identical in all geographical areas, these rates must reflect average costs. To the extent that a plan does not get a proportionate share of employees and dependents from both high- and low-cost areas, calculations of premium rates can be inaccurate to a considerable degree.

GOVERNMENT-WIDE SERVICE BENEFIT PLAN

Under the Federal Employees' Health Benefits Act (to be offered by Blue Cross-Blue Shield)

Kinds of Expenses	HIGH OPTION Basic Benefits	Deductible	Supplemental	LOW OPTION Basic Benefits	Deductible	Supplemental
Hospital Room and Board	*Up to 120 Days Per Admission in* — Member Hospital / Non-Member Hospital PLAN PAYS • in full / • $12.00 a day YOU PAY • nothing / • remainder	YOU PAY $100	PLAN PAYS 80% of ADDITIONAL ALLOWABLE EXPENSES up to $20,000 MAXIMUM SUPPLEMENTAL BENEFIT	Same as for High Option but up to 30 days	YOU PAY $200	PLAN PAYS 75% of ADDITIONAL ALLOWABLE EXPENSES up to $5,000 MAXIMUM SUPPLEMENTAL BENEFIT
Other Hospital Services	PLAN PAYS • in full / • 90% of actual charges YOU PAY • nothing / • remainder			Same as for High Option but up to 30 days		
Surgical and Medical	PLAN PAYS • amount set by fee schedule YOU PAY • any remainder			PLAN PAYS • amount set by fee schedule YOU PAY • the remainder		
Maternity	PLAN PAYS • up to $100 hospital expenses *plus* • amounts set by fee schedule for obstetrician & anesthesiologist YOU PAY • the remainder			PLAN PAYS • $10 a day hospital expenses up to 10 days *plus* • amounts set by fee schedule for doctor & anesthesiologist YOU PAY • the remainder		

Monthly Rates	*Govt.*	*Emp.*	*Total*		*Govt.*	*Emp.*	*Total*
Self Only	$ 2.82	$ 4.57	$ 7.39		$ 2.82	$ 2.82	$ 5.64
Family	6.76	12.61	19.37		6.76	7.45	14.21
Female with non-dependent husband	3.94	15.43	19.37		3.94	10.27	14.21

THROUGH . . .  *the Microscope*

Dr. Meyer Saklad to Address 109th A.M.A. Meeting at Miami

The 109th annual meeting of the American Medical Association will be a forum presented by some of the nation's top scientific brains.

Approximately 2,000 physicians, all outstanding in their field, will participate in presenting the scientific program of the meeting to be held in Miami Beach, June 13-17.

There will be two general scientific meetings in the Grand Ballroom of the Fontainebleau Hotel, and other lectures, symposia, and panel discussions in the Fontainebleau, Eden Roc Hotel, and in the new, air-conditioned Miami Beach Exhibition Hall. Sessions on dermatology, being held jointly with the Society for Investigative Dermatology, will be in the di Lido Hotel.

The opening general scientific meeting, Monday afternoon, June 13, will begin with the Joseph Goldberger Lecture on Clinical Nutrition. Dr. Carl A. Lincke, chairman of the A.M.A. Council on Scientific Assembly, will preside at this meeting.

The lecture will be followed by a symposium on nutrition, including an address by Grace A. Goldsmith, professor of medicine, Tulane University School of Medicine, New Orleans, on *Highlights on the Cholesterol—Fats, Diets and the Atherosclerosis Problem.*

The second general meeting will be a symposium on *Evaluation and Preparation of Patients for Anesthesia and Surgery,* Tuesday morning, June 14, to which the sections on Anesthesiology, Diseases of the Chest, General Practice, Internal Medicine, Pediatrics, Pathology and Physiology, and Surgery have contributed. Participating will be *MEYER SAKLAD, PROVIDENCE, R. I.;* Thomas Rardin, Columbus, Ohio; Eugene Turrell, Milwaukee, Wisconsin; John S. LaDue, New York City; Arlie R. Mansberger, Jr., Baltimore, Maryland; George Meneeley, Nashville, Tennessee; Robert M. Smith, Boston and C. Rollins Hanlon, St. Louis, Missouri.

Health Service Urges Polio Inoculation Programs

Supplies of unused polio vaccine have reached a high of 26.4 million doses although over 90 million Americans still need to be vaccinated, Doctor Leroy E. Burney, Surgeon General of the Public Health Service, reported last month.

"Every year, for the past four years, there has been a surplus of vaccine in the spring and winter followed by a shortage in the summer when the occurrence of polio cases reminds people they should get vaccinated," Doctor Burney said.

"This problem can be solved only if the public understands the following facts:

"1. The vaccine is most effective if used *before* polio is prevalent; the sooner you get vaccinated the greater will be your protection against polio this season.

"2. The vaccine manufacturing process takes about four months; if demand for vaccine is low now, supplies are likely to be low in the summer, since the present supply may be outdated by then.

"3. It is the third shot, due seven or more months after the first two that gives the greatest protection. A fourth shot a year after the third adds even greater protection."

Doctor Burney urged leaders of local medical societies, health departments and National Foundation chapters to carry out surveys in their communities to find the unvaccinated and persuade them to get their vaccinations promptly.

"Surveys can be completed within a few days by a system which the Public Health Service has developed and which we will be glad to provide to all communities that are interested," Doctor Burney said.

Most polio epidemics, Doctor Burney pointed out, now start in neighborhoods where there are concentrations of unvaccinated people. In these neighborhoods, infants and children under 5 are the victims. They have accounted for almost half of the paralytic cases that have occurred in the past two years.

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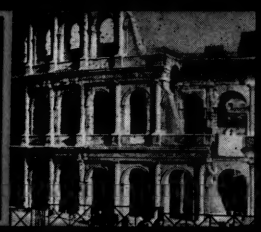
SPEED

DURATION



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THROUGH THE MICROSCOPE

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"About 5 million children in this age group have not had any polio vaccine and another 5 million have had only one or two injections. Thus about half of the nation's youngest and most vulnerable children still lack optimum protection against a disease that may cripple them for life," Doctor Burney said.

Most Workers Paid When Sick

Seven out of every ten workers covered by insurance programs under collective bargaining receive part of their salary when they are off the job because of illness or injury not connected with their work, the Health Insurance Institute reported recently. Nearly half of these workers also receive weekly income as a supplement to benefits paid by workmen's compensation for job-connected disabilities, said the Institute.

The report was based on an analysis of a U. S. Department of Labor study of 300 collectively bargained plans, each covering 1,000 or more workers. The plans covered a total of 4,933,000 workers or 40 per cent of all American workers under collectively bargained plans.

Of the 300 plans, 232 provided for weekly loss-of-income benefits to some 3.6 million workers. Thus, 77 per cent of all plans and 72 per cent of all workers were included in these programs, the Institute said.

A comparison of the plans at the end of 1955 and at the end of 1958 showed that the plans had generally been strengthened.

Key Findings: The principal findings of the 1958 study, said the Institute, were:

—Most workers were covered by plans which graduate benefits according to wages.

—Of the 99 plans with graduated benefits, 67 were graduated by hourly wages with benefits ranging up to $100 weekly. In the other 32 graduated plans, the usual benefit was 50 to 60 per cent of the weekly wage.

—Of the plans that paid a flat amount, the weekly benefit range was up to $65.

—Exactly half of the workers were covered by plans financed jointly by employer-employee contributions; forty-eight per cent of the workers were under plans to which only the employer contributed.

—Forty-five per cent of the workers were covered for both occupational and non-occupational disabilities, 54 per cent for non-occupational only, and one per cent for occupational only.

—The typical maximum duration of benefit payments was 26 weeks.

—More than half the plans provided benefits for income lost due to pregnancy; in practically all cases, the duration of benefits was six weeks, and a common benefit was $30 a week.

The extent to which the plans have been improved can be illustrated, said the Institute, by an examination of the number of workers earning $4,000 a year entitled to a certain level of benefits.

In 1955, some 28 per cent of the workers at this income level, when disabled, received benefits of more than $40 weekly. In 1958, the figure reached 49 per cent, the Institute stated.

The waiting period before a worker became eligible for benefits under the plans was less than three months for more than half of the employees.

Clifford R. Beadle (*right*) is congratulated by Francis R. Brown, president of Schering Corporation, Bloomfield, New Jersey, pharmaceutical manufacturer, after being named the company's *Salesman of the Year*.

Mr. and Mrs. Beadle reside at 71 Verndale Drive, East Greenwich, Rhode Island.

A native of East St. Louis, Illinois, Mr. Beadle was graduated from the Rhode Island College of Pharmacy and Allied Sciences following Air Force service in World War II. Prior to joining Schering in 1956, he was engaged in retail pharmacy for a number of years.

A registered pharmacist, Mr. Beadle is a member of the Rhode Island Pharmaceutical Association and the Kappa Psi fraternity.

Grant-in-Aid Program for Alcoholism Research Announced

This is a program through which relatively small research grants may be arranged quickly for competent scientists working in the field of alcoholism.

Licensed Beverage Industries, Inc., has made $500,000 available for a five-year program to meet the growing need for more scientific information both as to the extent of alcoholism and as to its causes and treatment.

The program is administered by a Scientific Advisory Committee whose members represent a wide range of relevant disciplines.

Grants will be awarded to qualified researchers in the biological and behavioral sciences who wish to make preliminary or pilot studies for the purpose of raising or clarifying particularly promising hypotheses.

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GONORRHEA IS ON THE MARCH AGAIN...

a new timetable for recovery:

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*Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

BRISTOL

BRISTOL LABORATORIES,
SYRACUSE, NEW YORK

THROUGH THE MICROSCOPE
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It is expected that grants will range between $2,000 and $10,000 and that they will run for one year. Renewal of the grant may be considered.

Detailed information and application forms may be obtained by writing to the Scientific Advisory Committee of the Licensed Beverage Industries, Inc., 155 East 44th St., New York 17, N. Y.

Reserve Officers Deferred for Residency Subject to Armed Forces Call

The Armed Forces continue to require the services of most physicians liable for military service under the Universal Military Training and Service Act.

Lt. General Lewis B. Hershey, director of Selective Service, issued this reminder to physicians when it became apparent recently that the Armed Forces would not call to active duty a small number of physicians in a few specialties who had been deferred for residency training under the Armed Forces Reserve Medical Officer Commissioning and Residency Consideration Program.

All reserve officers deferred for residency in most specialties will be called.

Shortages exist and will continue in certain specialties and in the group of officers who have not specialized, according to information received by the director of Selective Service from the office of Dr. Frank B. Berry, assistant secretary of Defense (Health and Medical).

The Selective Service director urged physicians not to draw erroneous conclusions concerning the need of the Armed Forces for their services. If a substantial number of physicians, basing their decision on knowledge that a few reserve medical officers in a few specialties are not being called to active duty after residency, conclude they are not needed, existing shortages in the Armed Forces will be aggravated.

The Department of Defense has found it unnecessary to requisition physicians through the Selective Service System since early in 1957. This has been so only because sufficient numbers of physicians sought reserve commissions and thus made themselves available for call to active duty.

There is a continuing need for applications for the residency program, as well as for reserve commissions and active duty at the conclusion of internship, General Hershey stressed.

The temporary surplus in some specialties in the residency program is understandable. Estimates of needs must be made four or five years ahead. Other factors are revisions in Armed Forces strength, redistribution of troops, reorganization of the hospital system, specialists choosing a military career, and voluntary extension of duty tours by reserve officers.

Visual Defects Reported Most Prevalent Physical Disability

More than half the people in this country have some kind of visual defect, according to a recent issue of PATTERNS OF DISEASE, a Parke, Davis & Company publication for the medical profession.

Only 43.5 per cent of Americans tested in one survey cited by PATTERNS had normal vision—that is, 20-30 vision or better in both eyes. Almost 1 in 10 were found to have the use of only one eye.

The impression this survey gives of a nation afflicted with weak eyes is strengthened by other figures reported in the publication. One out of every two Americans — an estimated total of 83,500,000 — wears either eyeglasses or contact lenses.

Further statistics show there are 960,000 blind persons in the country and an additional 2,064,000 with serious visual impairments. Together, blindness and poor vision rank fourth in the list of disabilities in the United States, outranked only by impairments of hearing; of the limbs, back and trunk; and disorders of the lower extremities.

When it comes to a question of the sexes, men do better visually than women. In one study of over 100,000 persons, it was found that in the 30-35 age group, approximately 42 per cent of men suffered from defective vision, compared to about 48 per cent of the women. In the over-40 age group, the difference was even more marked—about 10 to 12 per cent higher for women than for men.

Marked differences also are found in breakdowns by occupation. Clerical and administrative workers top the list of visually defective persons in one study reported by PATTERNS, with 51 per cent requiring glasses. At the other end of the list on the same survey are drivers of mobile equipment, with only 27.2 per cent wearing glasses.

Industrial workers as a group seem to be particularly vulnerable to eye trouble, not so much because of any inherent weakness as because of the high proportion of eye injuries that occur in industry.

"One thousand eye injuries occur every day of industrial operation," PATTERNS points out, adding that at least 90 per cent of these are needless and, aside from the physical and economic suffering of the victim and his family, "are highly costly to industry."

Most of these injuries could be avoided, as evidenced by the outstanding success of mandatory eye safety programs which certain industries have instituted, PATTERNS reveals. "One large Ohio plant which once had 500 to 600 eye injuries a month now has none." Another plant, in the East, has saved $1,000,000 in compensation costs.

Old Age—Chief Culprit: However, industry's role in accounting for the high prevalence of eye

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THROUGH THE MICROSCOPE

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disorders is minor compared to the chief culprit —old age. Each year, 30,000 Americans become blind, PATTERNS says, and of these the great majority are blinded by diseases associated with our increasing life-span. For instance, such conditions as senile cataract, glaucoma and other diseases of unknown etiology will claim 38 per cent—11,300 —of the newly blind. Other diseases like diabetes and vascular ailments will account for 6,300. Infectious diseases such as syphilis and trachoma will be responsible for only 1,300 of the newly blind.

Health Insurance Benefits Double in Five Years

American families received about $3.1 billion in benefits under voluntary health insurance during a 12-month period in 1957-58, Health Information Foundation reported recently—more than double the amount for a similar period five years earlier.

In its monthly statistical bulletin, PROGRESS IN HEALTH SERVICES, the Foundation published the third in a series of preliminary reports on a study made in co-operation with the National Opinion Research Center of the University of Chicago. A representative cross-section of American families were interviewed at length about what kinds of medical services they use and how they pay for these services.

The average insured family in 1957-58 had $80 in benefits from voluntary health plans, the Foundation revealed. This is an increase of 78 per cent over the $45 reported in a comparable survey for 1952-53.

Insurance benefits now pay for 24 per cent of the average insured family's total bill for hospital, medical, dental, and other health services, the H.I.F. report said. Five years earlier the figure was only 19 per cent.

One of the most significant findings of the survey, commented George Bugbee, Foundation president, is that families with unusually heavy costs for health care have been helped the most by recent increases in insurance benefits.

For example, families with health costs of $1,000 and over averaged $572 in benefits for 1957-58 against only $362 in 1952-53. Families spending between $750 and $1,000 in 1957-58 received $257 in benefits, while comparable families in 1952-53 received only $204.

Mr. Bugbee added, however, that there is "still room for improvement" in the proportion of unusually heavy medical expenses that voluntary health insurance can be expected to cover.

Among families with annual expenses of $500 or more in 1957-58, he noted, "only 24 per cent have 50 per cent or more of their total bill reimbursed by insurance. Benefits paid these high-cost families can be increased, as can the proportion of families who receive this protection against high costs, provided the public is willing to bear the cost of increased protection."

Many persons in the health field also believe that insurance should cover a broader range of preventive measures such as diagnostic services, Mr. Bugbee said. "There is evidence that such services can be covered, and their inclusion under health insurance coverage would undoubtedly encourage wider use by the public."

Pharmaceutical Association to Study Impact of Drug Costs

The Pharmaceutical Manufacturers Association announced recently the implementation of a full-scale probe of the impact of medicine costs on the American public. This is part of a major public service program of the association, according to its president, Doctor Austin Smith.

Doctor Smith said the full resources of the P.M.A. will be available for a broad study which will "bring together in one place information which has never been gathered in this country by any source, public or private."

Smith said the P.M.A. will determine: 1) The extent of use of prescription drugs by the general population; 2) The segments of the population using drugs and under what circumstances; 3) The ways in which drugs are being provided in medical care programs; 4) Whether needed drugs are not available to patients; 5) Which elements, if any, of the population may be deprived of necessary drug therapy and the reasons for such deprivation if it exists; 6) The true relationship of prescription drugs to medical care needs and costs.

Doctor Smith said representatives of consumer groups and various members of the health team will be asked to assist in the study with a special industry group, whose membership will be announced shortly.

DISTRICT MEDICAL SOCIETY MEETINGS

PROVIDENCE MEDICAL ASSOCIATION

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, March 7, 1960. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:30 P.M.

The reading of the minutes of the previous meeting was omitted.

The secretary reported that the Executive Committee recommended for election to active membership in the Association the following: Joseph Baruch, M.D.; Glidden L. Brooks, M.D.; Henry M. Litchman, M.D.

The motion was made, seconded, and unanimously adopted that the applicants recommended be elected to active membership.

The president called to the attention of the membership the scientific sessions to be held on Wednesday, March 23, under the auspices of the Rhode Island Heart Association.

He also announced that the film, *First Contact,* which the Program Committee had planned to show as part of the program this evening was not available and would be considered for a showing at a future meeting.

Doctor Beck reported that Doctor Donald Covalt had been detained in New York and, therefore, Doctor John Untereker, medical director of the Institute of the Crippled and Disabled of New York and a staff member of the Institute of Physical Medicine and Rehabilitation, would present the subject of *Rehabilitation in a General Hospital and the Practice Management of a Patient with Hemiplegia.*

Doctor Untereker outlined the responsibility of a department of physical medicine in a general hospital as follows:

1. *Fractures.* After definitive orthopedic therapy the department of physical medicine supervises exercises designed to preserve muscle function and to prepare the patient for future weight bearing. The physician in charge must encourage patient co-operation.
2. *Low Back Pain.* Here attention is paid chiefly to posture and muscle training of the abdominal, ham strings and abductor muscles. Instruction is given in correct back use.
3. *Degenerative C.N.S. Disease.* Remaining function must be kept intact so that the patient may maintain the function of natural living.
4. *Diagnosis.* Electomyelography is a major diagnostic tool which has proved very helpful when coupled with neourological data.
5. *Occupational therapy* is designed to maintain hand skills especially. It must be imaginative to avoid monotony.

Speech therapy is of questionable value in right hemiplegics as the extent of natural recovery cannot accurately be evaluated.

The department of physical medicine must have the active co-operation of the psychologists, psychiatrists and social service to care for the total patient properly.

Vocational rehabilitation is necessary in selected patients who cannot be returned to their previous occupations.

In treating hemiplegics due to cerebral palsy all medical resources must be pooled and all potentials must be recognized and used. Motivation of the patient is vital to success.

Hemiplegia following cerebral vascular accidents requires individualization as with cerebral palsy. The patient must be protected from contractures. He should sit up as soon as possible and proceed rapidly to weight bearing and return to natural living.

Doctor Joseph H. Dwinelle, Director of the Department of Physical Medicine at Rhode Island Hospital, led the discussion. He presented a right spastic hemiplegic patient on whom Doctor Untereker demonstrated some of the principles of proper management.

The meeting adjourned at 10:20 P.M.

Attendance was 78.

Collation was served.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

* * *

A regular meeting of the Providence Medical Association was held at the Rhode Island Medical Society Library on Monday, April 4, 1960. The meeting was called to order by the president, Doctor Irving A. Beck, at 8:30 P.M.

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DISTRICT MEDICAL SOCIETY MEETINGS

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The reading of the minutes of the previous meeting was omitted.

Nominees for Membership

Doctor William A. Reid, secretary, reported that the Executive Committee had reviewed and approved the applications for active membership in the Association of Doctors Joseph Dwinelle, John F. McCarthy, and Walter Thayer.

Action: It was moved that the nominees be elected. The motion was seconded and passed.

Amendments to the By-laws

The secretary reported that in order to bring the by-laws of the Association in accord with those of the Rhode Island Medical Society and the American Medical Association, the Executive Committee had approved changes as follows:

ARTICLE I, *Section 5. Treasurer.* Delete the following from this section: ". . . having first given such members and associate members sixty days written notice as provided in these by-laws. . . ."

ARTICLE III, *Membership. Section 2. Privileges of Membership.* Delete the words "sixty-five" and substitute the word "seventy" in the third paragraph so that the reading will be: "Any member who has arrived at the age of seventy years, . . . etc."

Section 6. Suspension for Delinquency in Payment of Dues. Amend the section to read: "Any member whose annual dues have not been paid on or before November 30 of each calendar year shall be suspended from membership in the Association."

Section 7. Forfeiture of Membership for Failure to Pay Dues. "Any member who fails to pay his annual dues and assessments within the calendar year shall forfeit his membership in the Association. Such member shall not be eligible for re-election to membership until all his undebtedness shall have been paid."

ARTICLE IV. *Dues. Section 1. Assessment of Dues.* Amend to read "Dues shall be levied at the annual meeting for the current year, and shall be payable when levied.

"Applicants elected to membership after September 30 shall be exempt from dues for the remainder of that calendar year, and the dues deposit made with the application shall be applied toward the member's dues for the ensuing year."

W. A. REID, M.D., *Secretary*

These changes had been published as part of the announcement to the membership of the April 4th meeting. He explained briefly the purpose of the amendments.

Action: It was moved that the amendments to the by-laws as published with the notice of the April 4 meeting of the Association be adopted. The motion was seconded and passed.

Annual Dinner and Golf Tournament

The secretary reported that the executive committee had approved of the plans of the committee on entertainment for the annual dinner and golf tournament of the Association, to be held on Wednesday, September 14, at the Newport Country Club.

Awarding of Membership Certificates

Doctor Beck presented certificates of membership to the physicians elected as active members of the Association at the March meeting.

Announcements by the President

Doctor Beck announced that the Association had lost by death one of its active members within the month, Doctor Robert E. Martin, and also that a former member, Doctor Gordon J. McCurdy, had died in Phoenix, Arizona, on February 14.

The members present stood for a minute of silent prayer.

The president called to the attention of the members the annual Cancer Conference of the Rhode Island Medical Society to be held at the Medical

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BOOK REVIEWS

A DOCTOR ENJOYS SHERLOCK HOLMES by Edward J. Van Liere. Vantage Press, N. Y., 1959. $3.00

In this interesting monographic essay, Van Liere reminds us of the master proficiency on weather, anatomy, brain fever, curare, the Portuguese man-of-war, the neuroses, botany, surgery, chemistry, endocrinology, genetics, zoology, cardiology, psychology, athletics, therapy and general practice.

A good source of information on sherlockiana.

F. RONCHESE, M.D.

TEXTBOOK OF OTOLARYNGOLOGY by David D. DeWeese and William H. Saunders. The C. V. Mosby Company, St. Louis, 1960. $8.75

This is a text which specifically states that it is designed primarily for the medical student and the general practitioner. It includes in its coverage of the field of otolaryngology many of the subjects often omitted in the standard text; that is, bronchoesophagology, the salivary glands, speech disorders and neck tumors. The chapters on hearing losses and audiometry concisely report the many recent advances made and are a must for the physician who wants to remain well informed. This book is unusually well illustrated with well-chosen photographs and drawings. The text emphasizes diagnosis and treatment in a manner that enables the reader to better appreciate and understand the specialty. Recommended.

FRANCIS L. MCNELIS, M.D.

MEDICAL LIBRARY HOURS
8:30 A.M. to 4:30 P.M.
In August: 8:30 A.M. to 1:00 P.M.

a book is to look at

buttons are to keep people warm

cats are so you can have kittens

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MEDICAL AND HEALTH CARE FOR THE AGED

Extension of Remarks

OF

HON. THOMAS B. CURTIS, *of Missouri*

in the House of Representatives

Tuesday, March 22, 1960

MR. CURTIS of Missouri. Mr. Speaker, March 23 I placed in the Appendix of the RECORD, page A2634, a speech that I gave before the American Academy of General Practice — physicians — at Kansas City, Mo. Three weeks later I gave the same speech before the convention of Missouri insurance agents in St. Louis, Mo. As I stated when I placed this in the RECORD, I prepared this speech to be delivered to these seemingly diverse groups. In this speech I discuss the general background of the problem that our society faces of medical care and hospital care for the aged.

I had expressed the belief in that speech that the tremendous progress made in our American society in advancing the well-being of all American citizens had made ineffective the demagoguery which was based upon using the Federal Government as a means of transferring wealth from the have to the have-nots. This belief is right now being placed to a more severe test than I had anticipated. I am wondering if indeed it is true that we can have a rational national debate on the subject of Federal spending.

A pressure group which is probably the most effectively organized for political action of any group in our society today has apparently decided to use the problem of medical and hospital care for the aged as an issue to test whether or not this kind of demagoguery can still be used successfully. This group is the Americans for Democratic Action, of which the most powerful segment is the Political Committee on Education of the CIO-AFL, dominated by Walter Reuther, a member of the ADA executive committee. The COPE of the CIO-AFL apparently has decided to abandon the issue of the Landrum-Griffin bill for the 1960 campaign and see whether or not they cannot make the Forand bill which professes to meet an aspect of the problem of the medical and hospital care for the aged do in its stead.

Those eligible for disability benefits would not be covered, nor would the measure provide for payments to mental or tuberculosis hospitals.

Despite the fact that old age is relative, and based upon physiological changes, the Social Security Act bases it on birthdays — 65 for a man, 62 for a woman.

By this standard, there are now some 15.5 million Americans over 65 who can be called aged.

This group is living evidence that we have the finest system of scientific medicine in the world, and that our standards of living are unparalleled in history.

Each year, our older population will increase. And by 1970 this fortunate Nation can expect to have 20 million people over 65.

But the growing numbers of our aged have, to some extent, caught us unprepared. For example, we are only beginning to understand the waste of human resources involved in arbitrary retirement of these people because of their chronological age.

And so millions of men and women—many of them as healthy and as capable as they were at 40 —are shelved long before they should be, long before they want to be.

With retirement, cash income usually drops. And at the same time, the need for health care services increases until it is about twice that of the younger adult.

It is this combination of lower income and greater need for health services that has led some well-meaning people to believe that medical expense is the most critical problem besetting our aged population.

In their opinion, only the Federal Government can provide an adequate answer.

Against this background, let us examine the premises upon which the supporters of H.R. 4700 base their arguments.

Although the health needs of our older people may be greater than those in other age groups, are the aged too poor to pay for their own medical care?

The answer is that some are, but the overwhelming majority are not.

We are told that three fifths of all people 65 and over have less than $1,000 annual income.

Although in one sense accurate, it would be hard to find a more misleading statistic.

It is equally accurate and just as misleading to state that in 1957—the most recent year to which that misleading figure applies—63.7 per cent of all Americans had incomes of $1,000 or less per year.

In 1957 almost half of those persons over 14 years of age also had incomes of $1,000 or less per year. And 47 per cent of those between the ages of 14 and 65 had incomes below $1,000 a year.

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MEDICAL AND HEALTH CARE FOR THE AGED

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Supposing we organize a social club with only two requirements for membership: First, that no wives had incomes of their own; and second that all husbands earned at least $25,000 a year.

If we used the same statistical techniques as those employed in compiling the figure of "three fifths of all people 65 and over have less than $1,000 annual income," we could come up with this statement:

Half the members of this social club have incomes of less than $1,000 a year.

Obviously, the money income figure cited by the Department of Health, Education, and Welfare for those 65 and over is of little help to us in considering the financial problems of the aged.

Income drops after retirement, yes. But no age group is likely to have as favorable a liquid asset position as the aged, 74 per cent of whom now own liquid assets in one form or another.

Furthermore, the needs of the aged person are usually modest. The heavy expenses of raising a family are behind. For the most part, homes are paid for. In fact, according to OASI, "almost three in every four beneficiary couples owned their own homes—most of them free of mortgage—and the median equity in nonfarm homes for the homeowners was $8,360."

Only 4 per cent live in the homes of relatives.

A survey in 1957 by the National Opinion Research Center determined that only 9.6 per cent of those interviewed would be unable to pay a medical bill of $500.

And so when we consider the financial resources of the aged, we can do it sensibly only if we know how many have income from employment, social security, pensions, annuities, savings, investments, insurance, or other assets.

We can only measure financial resources intelligently if we consider them in terms of family income and assets, not individual income and assets.

And when we attempt to figure out the number of people who cannot afford adequate health care, we must know how many already receive it from a religious group, a fraternal group, through membership in a union, as ex-seamen, as members of the Armed Forces, as professional courtesy, as members of specific religious orders, as veterans entitled to compensation and care.

We know, for instance, that 16 per cent of the aged are public welfare recipients. As such, under federally aided public assistance programs, they are eligible to receive medical care.

We do not know the answers to questions like these:

How much do the families of the aged help out? And how many of our older people are affluent?

My point is that the economic problems of older people are not only complex and diverse, but difficult to analyze precisely. Yet it is suggested that we take a serious and irreversible legislative action, with tremendously important consequences, with no real guideposts.

We are being asked to grope our way through the statistical darkness on the off-chance that we will stumble into an effective solution.

No one denies that there are instances of severe hardship among our older people—or among any other age group, for that matter. Such cases do exist, although to what degree we can only guess.

Certainly the weight of sound evidence seems to suggest one conclusion:

The financial and health problems of the aged have been considerably exaggerated by the proponents of Forand-type legislation. And on the basis of the facts as we presently know them, it is impossible to justify the creation of a massive Federal mechanism for compulsory national health insurance—even though that mechanism would deal only with a single and somewhat artificially determined category.

Implicit in the thinking of those who support H.R. 4700 is the belief that the health care needs of older people can be conveniently separated from their other needs. Nothing could be a greater mistake. Some of our aged have many needs—in housing, in recreation, in preparation for retirement, in finding acceptance, and understanding within the community, in developing new interests, in using talents, and capabilities.

As an example of how interrelated the needs of the aged can be, a former housing commissioner of the State of New York has pointed out that hospital confinement of older people could be reduced by 20 per cent if adequate housing were made available for them.

Further, the Nation's doctors have repeatedly stated that no person, regardless of age, needs to forego a physician's services because of inability to pay.

Expert medical testimony before the House Ways and Means Committee establishes another point: the aged have individual health needs. As Dr. Frederick C. Swartz told the Ways and Means Committee:

> Care for any segment of our population—the aged included—calls for a co-operative attack on the problem by nurses, doctors, hospitals, social workers, insurance companies, community leaders, and others. It requires flexibility of medical technique—an ingredient which would unquestionably vanish the moment Government establishes a health program from a blueprint calling for mass treatment.

In the case of the aged, their health problem primarily involves acute illness and the so-called degenerative diseases. In a very large percentage of cases, the main need is not for an expensive hospital stay or a surgical operation, but for medical care at home or in the doctor's office. In other cases, the important requirement is nursing care in the patient's home, or the home of relatives. And in still others, custodial care in a nursing home, or public facility may be the only answer. The point is that the medical needs of this particular segment of the aged are subject to countless variations.

The Forand bill, let me point out, wishes not only to grant the aged population most needy assistance but also to move the Federal Government into the very area of medical care where private insurance is now most effective—the area of hospitalization and surgery.

. . . Reprinted from the Appendix, *Congressional Record,* March 28, 1960

"Most older people are in good health. There are no such things as diseases of the aged. There are diseases among the aged, just as there are diseases to be found in any age group.

"We hear a great deal about the prevalence of so-called 'chronic illness' among older people. And so there is. But the term is generally misunderstood.

"The term 'chronic' simply refers to a recurrent condition, or one that persists over a period of time. It does not mean disability.

"I, for example, am chronically ill. I have impaired hearing and use a hearing aid. But I am neither disabled nor incapacitated.

"A diabetic is chronically ill but, with the help of insulin, can lead a perfectly normal life. Just a few years ago a diabetic played on our Davis Cup Tennis team.

"The chronically ill are simply impaired. Certain medical conditions limit certain of their capacities. They are not necessarily disabled.

"That is why I make the point that most of our older people are in good health. They should not be thought of as debilitated and sick, for in the main they are not."

. . . Abstracted from a statement made by Dr. James Z. Appel, a trustee of the American Medical Association, to the subcommittee on Problems of the Aged and Aging, Senate Labor and Public Welfare Committee, April 4, 1960.

ANNUAL DINNER . . . GOLF TOURNAMENT

Providence Medical Association

At Newport, Wednesday, September 14

DON'T GRIPE — WRITE

Your spokesmen in Washington are the two Senators from this State and the Representative from the 32d Congressional District. In Albany they are your State senator and assemblyman.

This is true whether they represent the political party to which you belong or an opposing party. Once they have been elected to public office they represent all the people.

But they cannot be expected to do a good job for you unless they understand your views and you, in turn, understand their problems. They need and want the opinions of all their constituents.

It must be remembered that a public official's first obligation is to his constituents. Their views are always given first place in his thoughts. Accurate and useful information sent by voters in his district is always appreciated. When he hears from "back home" it shows him the people know he is alive and are interested in what he is doing.

Until we realize our representatives welcome our views and we take the trouble to make them known, our relations in Washington and Albany will not be what they could be — or ought to be.

Remember, too, you don't have to wait until you have a complaint to register. Our elected officials are human, too, and a pat on the back is appreciated by them as it is by you. The important thing is: Don't gripe — write.

. . . Editorial, Amsterdam (N.Y.) EVENING RECORDER, March 28, 1960, as reprinted in the Appendix, *Congressional Record*, April 4, 1960

DISTRICT MEDICAL SOCIETY MEETINGS

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Library on Wednesday, April 20, and also the 149th Annual Meeting of the Society to be held on Tuesday, May 10 and Wednesday, May 11.

Scientific Program

Doctor Beck reported that Captain Anderson of Quonset, who had been originally scheduled to address the Association had been called out of the country within the week. He expressed his appreciation to Doctors Herbert Fanger, pathologist and chief of laboratories, Rhode Island Hospital, and Thomas H. Murphy, chief, Division of Cancer, State Health Department, for their willingness to present the program on such short notice on the subject of *Cancer in Situ of the Uterine Cervix*.

Doctor Fanger presented the report in which he summarized as follows:

Histologic and topographic studies have been made on 52 cone biopsies of the cervix containing carcinoma-in-situ and on 11 cases of atypical hyperplasia, 9 of "borderline" type. Cone biopsy appeared to be more desirable than other biopsy techniques because carcinoma-in-situ occasionally occurred in the endocervis and may not be included in the biopsy sample unless it is an adequate one. In addition, although frequently the tumor grew as a continuous sheet over large areas of the endocervix, in 20 of 52 cases, the tumor was found in only 1 or 2 segments. Therefore, the one biopsy would be more likely to detect the lesion than a more limited biopsy.

Superficial stromal invasion was infrequently seen and when present was not considered to alter the prognosis.

There were two unusual cases of carcinoma in situ with lymphatic invasion. In one, the lymphatic permeation was unusually extensive, and there were metastases to regional lymph nodes, despite the minimal carcinoma-in-situ and stromal involvement.

The complete paper is scheduled to appear in SURGERY, GYNECOLOGY AND OBSTETRICS, July, 1960.

The lecture was discussed by Doctors Henry C. McDuff, Jr., Thomas Perry, Jr., and Sumner Raphael.

Adjournment

The meeting adjourned at 9:30 P.M.

Attendance was 55.

Collation was served.

Respectfully submitted,

WILLIAM A. REID, M.D., *Secretary*

MEDICAL LIBRARY HOURS

8:30 A.M. to 1:00 P.M. *during August*

ON THE MEDICAL LIBRARY BOOKSHELVES

Twenty-two new titles have been added to the Davenport Collection and are available for circulation:

A BOOK THAT SHOOK THE WORLD. Anniversary Essays on Charles Darwin's "Origin of the Species." University of Pittsburgh Press, Pittsburgh, 1958.

Laurence Brander — TOBIAS SMOLLETT. Longmans, Green & Co., Lond., 1951.

A. J. Cronin — THE NORTHERN LIGHT. Little, Brown & Co., Boston, 1958.

Thomas A. Dooley—THE EDGE OF TOMORROW. Farrar, Straus & Cudahy, N.Y., 1958.

Rene Dubos—MIRAGE OF HEALTH. Utopias, Progress, and Biological Change. Harper & Brothers, N.Y., 1959.

Georges Guillain—J. M. CHARCOT. 1825-1893. His Life—His Work. Edited and translated by Pearce Bailey. Paul B. Hoeber, Inc., N.Y., 1959.

A. G. L. Ives—BRITISH HOSPITALS. Collins, Lond., 1948.

Hannes Lindemann—ALONE AT SEA. Edited by Jozefa Stuart. Random House, N.Y., 1958.

Eleazar Lipsky—THE SCIENTISTS. Appleton, Century, Crofts, Inc., N.Y., 1959.

Ralph H. Major—DISEASE AND DESTINY. LOGAN CLENDENING. Logan Clendening Lectures on the History and Philosophy of Medicine. 8th series. University of Kansas Press, Lawrence, 1958.

W. Somerset Maugham—POINTS OF VIEW. Doubleday & Co., Inc., Garden City, 1959.

Andre Maurois—THE LIFE OF SIR ALEXANDER FLEMING, Discoverer of Penicillin. Translated from the French by Gerard Hopkins and with an Introduction by Professor Robert Cruickshank. E. P. Dutton & Co., Inc., N.Y., 1959.

A PSYCHIATRIST'S WORLD. The Selected Papers of Karl Menninger, M.D. Edited, with an Introduction by Bernard H. Hall. Foreword by Marion E. Kenworthy. The Viking Press, N.Y., 1959.

Daniel Paul (A. W. Lipmann-Kessel) & John St. John—SURGEON AT ARMS. W. W. Norton & Co., Inc., N.Y., 1958.

Samuel Rapport & Helen Wright, editors — GREAT ADVENTURES IN MEDICINE. Dial Press, N.Y., 1956.

Leonard G. Rowntree—AMID MASTERS OF TWENTIETH CENTURY MEDICINE. A Panorama of Persons and Pictures. With an introduction by George F. Lull. Charles C Thomas, Springfield, Ill., 1958.

J. E. Schmidt—DICTIONARY OF MEDICAL SLANG AND RELATED ESOTERIC EXPRESSIONS. Charles C Thomas, Springfield, Ill., 1959.

J. E. Schmidt — MEDICAL DISCOVERIES. Who and When . . . Charles C Thomas, Springfield, Ill., 1959.

R. R. Simpson—SHAKESPEARE AND MEDICINE. E. & S. Livingstone Ltd., Edin. & Lond., 1959.

Charles Singer — A SHORT HISTORY OF ANATOMY AND PHYSIOLOGY FROM THE GREEKS TO HARVEY. Dover Publications, Inc., N.Y., 1957.

William Carlos Williams—PATERSON. Book Five. New Directions, N.Y., 1958.

William Carlos Williams — YES, MRS. WILLIAMS. McDowell, Obolensky, N.Y., 1959.

The Veterinary Collection has acquired the following volumes:

William Arthur Hagen & Dorsey William Bruner — THE INFECTIOUS DISEASES OF DOMESTIC ANIMALS WITH SPECIAL REFERENCE TO ETIOLOGY, DIAGNOSIS, AND BIOLOGIC THERAPY. 3rd ed. Comstock Publishing Associates, Ithaca, 1957.

Hilton Atmore Smith & Thomas Carlyle Jones—VETERINARY PATHOLOGY. Lea & Febiger, Phil., 1957, repr. 1958.

Alfred Trautmann & Josef Fiebeger—FUNDAMENTALS OF THE HISTOLOGY OF DOMESTIC ANIMALS. Translated and revised from the eighth and ninth German edition by Robert E. Habel & Ernst L. Biberstein. Comstock Publishing Associates, Ithaca, 1957.

The generosity of the Rhode Island Veterinary Medical Association enables us to buy needed books in this field.

Other purchases were:

Silvano Arieti & others, editors—AMERICAN HANDBOOK OF PSYCHIATRY. 2 vols. Basic Books, Inc., N.Y., 1959.

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Richard Travis Atkins & Jane McGlennon Atkins —THE WORLD TRAVELER'S MEDICAL GUIDE. Simon & Schuster, N.Y., 1958.

John H. Bland—ARTHRITIS. Medical Treatment and Home Care. The Macmillan Company, N.Y., 1960.

Sydney M. Cockerell—THE REPAIRING OF BOOKS. Sheppard Press, Lond., 1958.

COLLECTED PAPERS OF THE MAYO CLINIC AND THE MAYO FOUNDATION, vol. 50, 1958. W. B. Saunders Co., Phil., 1959.

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Robert H. Durham — ENCYCLOPEDIA OF MEDICAL SYNDROMES. Paul B. Hoeber, Inc., N.Y., 1960.

Alfred Hurwitz & George A. Degenshein—MILESTONES IN MODERN SURGERY. With a Foreword by J. Englebert Dunphy. Hoeber-Harper Books, N.Y., 1958.

S. Leon Israel—Mazer & Israel's DIAGNOSIS AND TREATMENT OF MENSTRUAL DISORDERS AND STERILITY. 4th ed. Paul B. Hoeber, Inc., 1959.

Elliott P. Joslin & others—THE TREATMENT OF DIABETES MELLITUS. 10th ed. rev. Lea & Febiger, Phil., 1959.

James Howard Means—WARD 4. The Mallinckrodt Research Ward of MGH. With a Foreword by Charles Sidney Burwell. Harvard University Press, Cambridge, 1958.

THE MERCK INDEX OF CHEMICALS AND DRUGS. An Encyclopedia for Chemists, Pharmacists, Physicians, and Members of Allied Professions. Rahway, N.J., 1960.

William Montagna—THE STRUCTURE AND FUNCTION OF SKIN. Academic Press, N.Y., 1956.

Oscar E. Nybakken—GREEK AND LATIN IN SCIENTIFIC TERMINOLOGY. Iowa State College Press, Ames, Iowa, 1959.

PROGRESS IN NEUROLOGY AND PSYCHIATRY. An Annual Review edited by E. A. Spiegel. Vol. 14. Grune & Stratton, N.Y., 1959.

Siegfried J. Thannhauser — LIPIDOSES. Diseases of the Intracellular Lipid Metabolism. Grune & Stratton, N.Y., 1958.

YEAR BOOK OF CANCER, 1958-1959 Series. Compiled and edited by Randolph Lee Clark, Jr. and Russell W. Cumley. The Year Book Publishers, Inc., Chic., 1959.

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YEAR BOOK OF ENDOCRINOLOGY, 1958-1959 Series. Edited by Gilbert S. Gordan. The Year Book Publishers, Inc., Chic., 1959.

YEAR BOOK OF GENERAL SURGERY, 1959-1960 Series. Edited by Michael E. DeBakey. With a Section on Anesthesia edited by Stuart C. Cullen. The Year Book Publishers, Inc., Chic., 1959.

YEAR BOOK OF MEDICINE, 1959-1960 Series. Edited by Paul B. Beeson & others. The Year Book Publishers, Inc., Chic., 1959.

YEAR BOOK OF PATHOLOGY AND CLINICAL PATHOLOGY. 1958-1959 Series. Edited by William B. Wartman. The Year Book Publishers, Inc., Chic., 1959.

Review volumes from the Rhode Island Medical Journal were:

James H. Allen, editor—STRABISMUS OPHTHALMIC SYMPOSIUM II. The C. V. Mosby Co., St. L., 1958.

Maude Behrman—A COOKBOOK FOR DIABETICS. Recipes from the *ADA Forecast*. Edited by Leonard Louis Levinson. American Diabetes Association, N.Y., 1959.

Smiley Blanton and Arthur Gordon—NOW OR NEVER. The Promise of the Middle Years. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1959.

Lawrence R. Boies — FUNDAMENTALS OF OTOLARYGOLOGY. A Textbook of Ear, Nose and Throat Diseases. 3rd ed. W. B. Saunders Co., Phil., 1959.

Morris W. Brody — OBSERVATIONS ON DIRECT ANALYSIS. The Therapeutic Technique of Dr. John N. Rosen. Vantage Press, N.Y., 1959.

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swer to this Problem . . . Philosophical Library, N.Y., 1958.
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Harry F. Dowling & Tom Jones—THAT THE PATIENT MAY KNOW. An Atlas for use by the Physician in Explaining to the Patient. W. B. Saunders Co., Phil., 1959.
Robert H. Dreisbach—HANDBOOK OF POISONING: Diagnosis and Treatment. 2nd ed. Los Altos, Calif. Lange Medical Publications. 1959.
Henri L. DuVries — SURGERY OF THE FOOT. The C. V. Mosby Co., St. L., 1959.
John W. Gofman, Alex V. Nichols and E. Virginia Dobbin — DIETARY PREVENTION AND TREATMENT OF HEART DISEASE. G. P. Putnam's Sons, N.Y., 1958.
James D. Hardy, James C. Griffin, Jr. & Jorge A. Rodriguez—BIOPSY MANUAL. W. B. Saunders Co., Phil., 1959.
Herman E. Hilleboe and Granville W. Larimore, editors—PREVENTIVE MEDICINE. Principles of Prevention in the Occurrence and Progression of Disease. W. B. Saunders Co., Phil., 1959.
Israel S. Wechsler—A TEXTBOOK OF CLINICAL NEUROLOGY. 8th ed. W. B. Saunders Co., Phil., 1958.
Albert G. Love, Eugene L. Hamilton and Ida Levin Hellman — TABULATING EQUIPMENT AND ARMY MEDICAL STATISTICS. Office of the Surgeon General, Department of the Army, Wash., D.C., 1958.
Medical Department, U. S. Army—PREVENTIVE MEDICINE IN WORLD WAR II. Vol. IV. Communicable Diseases Transmitted Chiefly through Respiratory and Alimentary Tracts. Wash., D.C., 1958.
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Francis D. Moore—METABOLIC CARE OF THE SURGICAL PATIENT. W. B. Saunders Co., Phil., 1959.
John H. Moyer & others, editors—HYPERTENSION. The first Hahnemann Symposium on Hypertensive Disease. W. B. Saunders Co., Phil., 1959.
Eugene B. Mozes—LIVING BEYOND YOUR HEART ATTACK. Prentice-Hall, Inc., Englewood Cliffs, N.J., 1959.
Waldo E. Nelson, editor — TEXTBOOK OF PEDIATRICS. 7th ed. W. B. Saunders Co., Phil., 1959.

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Joseph H. Peck — WHAT NEXT, DOCTOR PECK? Prentice-Hall, Inc., Englewood Cliffs, N.J., 1959.
Edward Podolsky, editor — THE NEUROSES AND THEIR TREATMENT. Philosophical Library, N.Y. (1958).
William J. Potts — SURGEON AND THE CHILD. W. B. Saunders Co., Phil., 1959.
Edward H. Richardson—A DOCTOR REMEMBERS. Vantage Press, N.Y., 1959.
Stuart T. Ross — SYNOPSIS OF TREATMENT OF ANORECTAL DISEASES. The C. V. Mosby Co., St. L., 1959.
Paul J. Sanazaro, editor — CURRENT MEDICAL REFERENCES. Lange Medical Publications, Los Altos, Calif.
Hans Selye — THE CHEMICAL PREVENTION OF CARDIAC NECROSES. Ronald Press Co., N.Y., 1958.
Boris Sokoloff—DOCTOR STRAND. Vantage Press, N.Y., 1959.
Julian A. Sterling—A PRACTICAL GUIDE TO GENERAL SURGICAL MANAGEMENT. Vantage Press, N.Y., 1959.
Edward J. Van Liere—A DOCTOR ENJOYS SHERLOCK HOLMES. Vantage Press, N.Y., 1959.
Curt S. Wachtel—YOUR MIND CAN MAKE YOU SICK OR WELL. Prentice-Hall, Inc., Englewood Cliffs, N. J., 1959.

Fellows of the Society have given the following items:

Gifts of periodicals from:—Doctors John T. Barrett, Irving A. Beck, Donald DeNyse, Banice Feinberg, Manual Horwitz, Walter S. Jones, Lewis B. Porter and Charles Potter.
Gifts of books and pamphlets from:—
Dr. Kenneth G. Burton—reprints.
Dr. John E. Donley—ON THE USE OF THE OPHTHALMOSCOPE IN DISEASES OF THE NERVOUS SYSTEM AND OF THE KIDNEYS . . . by Thomas Clifford Allbutt. Macmillan & Co., Lond. & N.Y., 1871.
Dr. Seebert J. Goldowsky—The Source Material, Photostats and Correspondence Pertaining to his Article on the PORTSMOUTH GROVE HOSPITAL.
Dr. Walter S. Jones — TRANSACTIONS OF THE NEW ENGLAND OBSTETRICAL AND GYNECOLOGICAL SOCIETY, vol. 12 for 1958. Bost., 1959.
Dr. Francis J. McCabe — ATLAS OF EXTERNAL DISEASES OF THE EYE by A. Maitland Ramsay. J. Maclehose & Sons, Glasgow. 1898.
—ATLAS OF OPHTHALMOSCOPY . . . by R. Liebreich. Translated by H. Rosborough Swanzy. 3rd ed. J. & A. Churchill Co., Lond., 1885. These volumes belonged originally to Dr. Frederick T. Rogers who gave them to Dr. McCabe.
Dr. John D. Pitts—16 volumes.
Dr. Arnold Porter—10 volumes.
Dr. Francesco Ronchese—PICA . . . by Marcia Cooper. Charles C Thomas, Springfield, Ill., 1957.
—GOLDEN AGE OF QUACKERY by Stewart H. Holbrook. The Macmillan Co., N.Y., 1959.
—PAPERS PRESENTED AT A SYMPOSIUM ON ANTIBACTERIAL THERAPY. Michigan and Wayne County Academies of General Practice. September 12, 1959, Detroit.
—LA DIFESA DELLA SALUTE UMANA NEGLI STATI UNITI D'AMERICA . . . by Francesco Piccininni. Napoli, 1925.
Dr. Roswell S. Wilcox — UROLOGY. DISEASES OF THE URINARY ORGANS . . . by Edward L. Keyes, Jr. D. Appleton & Co., N.Y., 1917.

SUCCESSFUL TRIAL

Detroit **— Michigan Blue Cross's experiment with homecare coverage has ended its first month with flying colors — and an estimated saving of 560 days of in-hospital care. The 33 cases concerned were selected from four Detroit-area hospitals, and both long-term and acute diseases were represented, Blue Cross revealed.**

Some 300 cases will eventually be involved in the year-long study to determine whether homecare benefits appreciably cut down hospital stays. It is expected to lead to inclusion of such benefits in standard contracts, at no extra cost, as an extension of general hospital benefits. The plan's prototype is the home-care program to be launched next month by Associated Hospital Service of New York, after a five-year study.

(As reported in MEDICAL NEWS)

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Marcello Malpighi—DE PULMONIBUS. Ristampa, Traduzione Italiana e Introduzione a cura di Luigi Belloni. Milan, 1958. Gift of Dr. Belloni.

COLLECTION OF CHAPINIANA. Gift of Mr. James Cassidy.

Tom Mahoney — THE MERCHANTS OF LIFE. Harper & Brothers, N.Y., 1959. Gift of Mr. John E. Farrell.

Polk's PROVIDENCE CITY DIRECTORY, vol. 114, 1954. Gift of Mr. Vincent O'Brien.

Sheldon H. Malinou & Moira Davison Reynolds —ACID PHOSPHATASES OF THE LUTZ AND WALKER 256 TUMORS. repr. Enzymologia, v. 21, 1959, pp. 123-8. Gift of Mr. Malinou.

Homer W. Smith—FROM FISH TO PHILOSOPHER. The Story of Our Internal Environment. Ciba ed. enl. & rev. Summit, N.J., 1959. 2 copies. Gift of Mr. Morton W. Saunders.

SIXTH ANNUAL MEETING OF THE INTER-SOCIETY CYTOLOGY COUNCIL. TRANSACTIONS. Statler Hotel, New York City, Nov. 13, 14 and 15, 1958. Gift of the American Cancer Society.

TRANSACTIONS OF THE AMERICAN CLINICAL AND CLIMATOLOGICAL ASSOCIATION, 71, 1958. v. 70, 1959. Gift of the Association.

J. Arthur Myers — A HISTORY OF THE AMERICAN COLLEGE OF CHEST PHYSICIANS. Silver Anniversary, 1935/1959. Gift of the College.

TRANSACTIONS OF THE ASSOCIATION OF AMERICAN PHYSICIANS, 72nd session vol. LXXII, 1959. Gift of the Association.

TRANSACTIONS OF THE ASSOCIATION OF LIFE INSURANCE MEDICAL DIRECTORS OF AMERICA, 67th Annual Meeting, v. 42, N.Y., 1959. Gift of the Association.

Council on Drugs, A.M.A.—NEW AND NONOFFICIAL DRUGS 1960. J. B. Lippincott Co., Phil., 1960. Gift of the American Medical Association.

DIRECTORY OF MEMBERS, BYLAWS, STATEMENT OF POLICY, ORGANIZATIONAL LISTINGS OF THE AMERICAN SOCIETY OF ANESTHESIOLOGISTS, INC. January 1960. Gift of the Society.

REPORT OF THE MEDICAL RESEARCH COUNCIL for the Year 1957-1958. Lond., 1959. Gift of the British Government.

CLINICAL CONFERENCE OF THE CHICAGO MEDICAL SOCIETY March 2-5, 1959. Gift of the Society.

CIBA FOUNDATION COLLOQUIA ON AGEING. Vol. 5. The Lifespan of Animals. Little, Brown & Co., Bost., 1959. Gift of the Foundation.

CIBA FOUNDATION SYMPOSIUM—Carcinogenesis. Mechanisms of Action. Little, Brown & Co., Bost., 1959. Gift of the Foundation.

CIBA FOUNDATION SYMPOSIUM—Regulation of Cell Metabolism. Little, Brown & Co., Bost., 1959. Gift of the Foundation.

CIBA FOUNDATION SYMPOSIUM Jointly with the INTERNATIONAL UNION OF BIOLOGICAL SCIENCE—On Biochemistry of Human Genetics. Little, Brown & Co., Bost., 1959. Gift of the Foundation.

Ciba Foundation — TENTH ANNIVERSARY SYMPOSIUM ON SIGNIFICANT TRENDS IN MEDICAL RESEARCH. Little, Brown & Co., Bost., 1959. Gift of the Foundation.

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COLLECTED STUDIES FROM THE CITY OF CHICAGO MUNICIPAL TUBERCULOSIS SANITARIUM, vol. XI, 1956-1959. Gift of City of Chicago.

PROCEEDINGS OF THE INTERNATIONAL COLLOQUIUM ON RESISTANT INFECTIONS Under the Auspices of the World Medical Association & Eaton Laboratories. Norwich, N.Y., 1958. Gift of Eaton Laboratories.

Health Insurance Institute—SOURCE BOOK OF HEALTH INSURANCE DATA, 1959. N.Y., Gift of the Institute.

Joint Blood Council — DIRECTORY OF BLOOD TRANSFUSION FACILITIES AND SERVICES. Wash., 1958. Gift of the Council.

Charles Mayo Goss—A BRIEF ACCOUNT OF HENRY GRAY, F.R.S., AND HIS ANATOMY, DESCRIPTIVE AND SURGICAL . . .

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LIFE INSURANCE MEDICAL RESEARCH FUND. Fourteenth Annual Report. 1959. Gift of the Fund.

W. Lojander — COMMUNICATIONS FROM THE DEPARTMENT OF HYGIENE, UNIVERSITY OF HELSINKI 1935-1959. Helsinki, 1959. Gift of the Author.

ANNUAL REPORT OF THE JOHN AND MARY R. MARKLE FOUNDATION, 1958-59. Gift of the Foundation.

DR. CARLOS J. FINLAY AND THE "HALL OF FAME" OF NEW YORK. Preface by Dr. Serafin Ruiz de Zarate, Havana, 1959. Gift of the Ministerio de Salubridad, Cuba.

COLLECTED REPRINTS OF THE GRANTEES OF THE NATIONAL FOUNDATION FOR INFANTILE PARALYSIS, v. 19, pts. 1 & 2. N.Y., n.d. Gift of the National Foundation.

PROCEEDINGS OF THE TENTH ANNUAL CONFERENCE ON THE NEPHROTIC SYNDROME. N.Y., 1959. Gift of the National Kidney Disease Foundation.

INDEX-CATALOGUE OF THE LIBRARY OF THE SURGEON-GENERAL'S OFFICE, National Library of Medicine. 5th series, vol. 1. Wash., 1959. Gift of the National Library.

Christopher Tietze — THE CONDOM AS A CONTRACEPTIVE. N.Y., 1960. Gift of the National Committee on Maternal Health, Inc.

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THE PRESIDENT'S REVIEW Including a Quarter Century in the Natural Sciences by Warren Weaver. Rockefeller Foundation, N.Y., 1959. Gift of the Foundation.

ROSS CONFERENCES ON PEDIATRIC RESEARCH, 31st, 32nd, 33rd, 1959. Gift of Ross Laboratories.

State Department of Health of Connecticut—ONE HUNDRED AND EIGHTH REGISTRATION REPORT, 1955. Gift of the State of Connecticut.

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BOOKS IN PRINT, 1957. Gift of the Veterans Administration Hospital.

CUMULATIVE BOOK INDEX, 1953-1958, 9 volumes. Gift of the Veterans Administration Hospital.

TRANSACTIONS OF THE WESTERN SECTION OF THE AMERICAN UROLOGICAL ASSOCIATION, vol. 27, 1959. Gift of the Association.

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Academy of Medical Sciences USSR Institute of Experimental Pathology and Therapy of Cancer —PROBLEMS OF ETIOLOGY AND PATHOGENESIS OF TUMORS. Edited by Professor N. N. Blokhin. Wash., 1959.

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Division of Medical Statistics, Ministry of Health,

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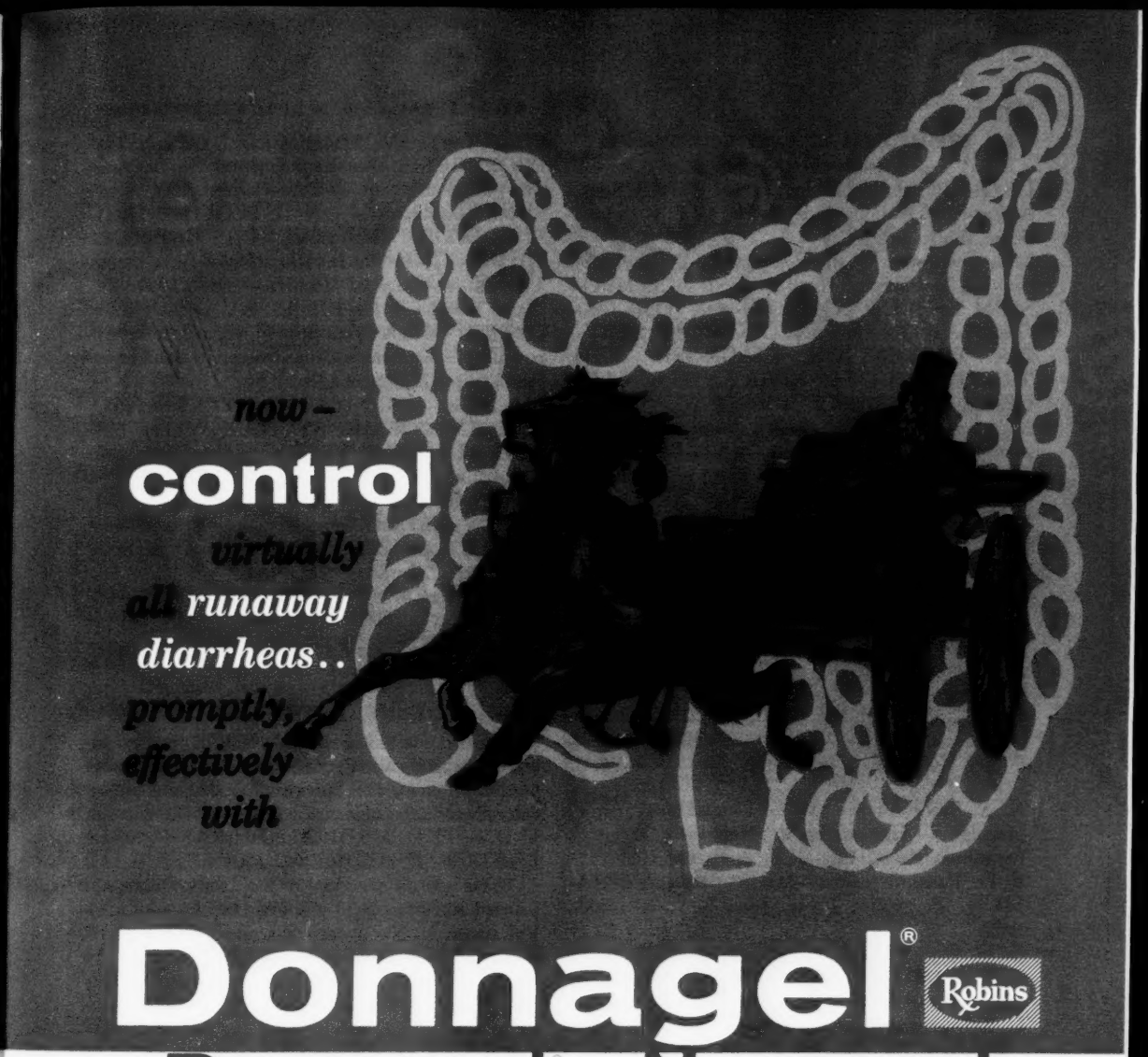

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USSR—PUBLIC HEALTH IN THE USSR. A Statistical Handbook. Edited by G. F. Konstantinov. Wash., 1959.

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A. A. Smorodintsev, V. G. Chudakov & A. V. Churilov — Haemorrhagic Nephroso-Nephritis. Pergamon Press, Inc., N.Y. & Lond., 1959.

V. D. Timakov, editor—MICROBIAL VARIATION. Pergamon Press, Inc., N.Y. & Lond., 1959.

G. V. Vygodchikov, editor—PATHOGENESIS AND IMMUNOLOGY OF TUMOURS. Pergamon Press, Inc., N.Y. & Lond., 1959.

U. S. Department of Agriculture—INDEX CATALOGUE OF MEDICAL AND VETERINARY ZOOLOGY. Sup. 9. Wash., 1959.

We received gifts of periodicals from the following:

Charles V. Chapin Hospital, Maricopa County Medical Society Library, Peters House Library at Rhode Island Hospital, Rhode Island State Department of Health Library, St. Joseph's Hospital Library, State Board of Health of Mississippi Library, University of Kentucky Medical Library, Veterans Administration Hospital Library and the Veterans Administration Regional Office.

Through our Exchange with Lund University, we acquired:

Sigfrid Fregert—STUDIES ON SILICON IN TISSUES WITH SPECIAL REFERENCE TO SKIN. Acta derm.-venereol. sup. 42. Lund, 1959.

Knut Haeger — COLLATERAL CORONARY CIRCULATION PRODUCED BY PLASTIC PROSTHESIS. An Experimental Study. Acta chir. scandinav. sup. 243. Stockholm, 1959.

Stefan Haraldsson — ON OSTEOCHONDROSIS DEFORMANS JUVENILIS CAPITULI HUMERI Including Investigation of Intra-osseus Vasculature in Distal Humerus. Lund, 1959.

Claus Rerup—THE BIOASSAY OF CORTICOTROPHIN A With Special Regard to the Effect after Subcutaneous Administration. Acta endocrinol. sup. 42. Copenhagen, 1958.

Lars Rohl — PROSTATIC HYPERPLASIA AND CARCINOMA STUDIED WITH TISSUE CULTURE TECHNIQUE. Acta chir. scandinav. sup. 240. Stockholm, 1959.

Sven Svennerud—DYSMENORRHOEA AND ABSENTEEISM. Some Gynaecologic and Medico-social Aspects. Acta obst. et gynecol. scandinav. v. 38, sup. 2, Lund, 1959.

Arne Weiber — STUDIES IN VASCULARISATION OF HEALING WOUNDS WITH RADIOACTIVE ISOTOPES. Acta chir. scandinav. sup. 237. Stockholm, 1959.

FRIENDS OF THE LIBRARY

"The periodical is the only element of medical literature actually abreast of the times and alone supplies that up-to-date information that the up-to-date physician requires. . . ." George D. Hersey, M.D. — THE MEDICAL LIBRARY AS A FACTOR IN MEDICAL PROGRESS.

These words are doubly true today when the printed word has hard work to keep up with medical research. No library has enough journals to answer the demand and few libraries have the funds with which to buy even the absolute essentials. *Therefore, we are grateful for the help given us by the Friends who provide the following periodicals:*

American Cancer Society, R. I. Division, Inc.—CA, CANCER, CANCER BULLETIN, CANCER CURRENT LITERATURE and EXCERPTA MEDICA: Cancer.

Irving A. Beck, M.D.—JOURNAL OF THE MT. SINAI HOSPITAL.

Francis V. Corrigan, M.D. — AMERICAN JOURNAL OF PUBLIC HEALTH.

John E. Farrell, Sc. D.—AMERICAN JOURNAL OF PUBLIC HEALTH, SOCIAL SECURITY BULLETIN and many County Society Bulletins.

Seebert J. Goldowsky, M.D.—MD :Medical Newsmagazine.

Walter S. Jones, M.D.—WESTERN JOURNAL OF SURGERY, OBSTETRICS AND GYNECOLOGY.

Louis I. Kramer, M.D.—ANNALS OF INTERNAL MEDICINE.

concluded on page 371

ON THE MEDICAL LIBRARY BOOKSHELVES

concluded from page 366

Drs. Morris L. & Ralph Povar—AMERICAN JOURNAL OF VETERINARY RESEARCH and the JOURNAL OF THE AMERICAN VETERINARY MEDICAL ASSOCIATION.
Providence Medical History Club—BULLETIN OF THE HISTORY OF MEDICINE.
Rhode Island Arthritis and Rheumatism Foundation, Inc.—ARTHRITIS AND RHEUMATISM and BULLETIN ON RHEUMATIC DISEASES.
Rhode Island Chapter, Physical Therapy Association—PHYSICAL THERAPY REVIEW.
Rhode Island Heart Association, Inc.—CIRCULATION RESEARCH and MODERN CONCEPTS OF CARDIOVASCULAR DISEASE.
Rhode Island State Department of Health—THE HEART BULLETIN.
Francesco Ronchese, M.D.—JOURNAL OF INVESTIGATIVE DERMATOLOGY, JOURNAL OF THE SCIENCE OF LABOUR and ORRIZONTE MEDICO. Dr. Ronchese has been responsible, also, for arranging most of our exchanges with medical journals published in Italy.

EXHIBITS-ON-FILM

The Lakeside Laboratories, Inc. of Milwaukee, have provided the Library with the following filmstrips, together with recorded commentaries. These are available for loan.

I. (1) Indications for Cardiac Surgery. (2) Oral Organomercurial Diuretics.
II. (1) Hands in Arthritis. (2) Intramuscular Iron in Infancy.
III. (1) Bronchial Asthma. (2) Direct Intracardiac Surgery.
IV. Bone Marrow Patterns in Infancy and Childhood.
V. (1) Cancer Cells in the Circulating Blood. (2) Hematopoietic Response to Iron Dextran Therapy.
VI. Bronchopulmonary Problems in Pediatrics.
VII. (1) Chemopallidectomy for Dystonia. (2) Care of Minor Hand Injuries.
VIII. The Hemodynamic Concept of Atherosclerosis.
IX. (1) The Intestinal Biopsy Capsule. (2) Small Intestinal Biopsy in Steatorrhea.

MEDICARE FEES HIGH ENOUGH

Physicians should be satisfied with their Medicare fee schedules "for some time to come," according to Brig. Gen. Floyd L. Wergeland, executive director of this program for providing health and hospital services to dependents of military personnel. "We believe we are paying physicians' fees that probably approach the upper limits of fairness," he told a recent meeting of the Dependents' Medical Care Advisory Committee. "It is not sound policy for us to accept inflation as a justification for increasing the fee schedules."

... As quoted by the WASHINGTON REPORT on the *Medical Sciences*, May 9, 1960

ANNUAL BUSINESS MEETING
of the
RHODE ISLAND MEDICAL SOCIETY
May 11, 1960

THE INSTALLATION of officers and elected committees to serve the Society for the fiscal year from May, 1960, until May, 1961, and the adoption of an amendment to the by-laws to change the Medical Defense and Grievance Committee to a ten-member committee with staggered terms up to ten years, featured the annual business meeting held on May 11.

Doctor Earl J. Mara, Pawtucket internist, was installed as the 101st president of the Society, succeeding Doctor Alfred L. Potter. Others elected and installed were the following: Doctor Frank W. Dimmitt, Providence ophthalmologist, vice president; Doctor Samuel Adelson, Newport surgeon, president-elect; Doctor Arthur E. Hardy, surgeon from Warwick, re-elected secretary; and Doctor J. Murray Beardsley, Providence surgeon, re-elected treasurer.

The membership approved of the by-law amendment submitted by the House of Delegates which re-establishes the committee on Medical Defense and Grievance. The by-law as now effective is as follows:

"*Article X. Section 7. Medical Defense and Grievance.* The Committee on Medical Defense and Grievance shall consist of ten (10) members, in addition to the president and the secretary of the Society, *ex officio*. Initially the committee shall be appointed as follows: the president of the Society shall appoint one member in 1960 who shall serve a term of ten (10) years, and with the advice and consent of the Council he shall appoint nine (9) additional members who, at their first organizational meeting, shall draw lots to determine the length of their terms — one, for nine years; one, for eight years; one, for seven years; one, for six years; one, for five years; one, for four years; one, for three years; one, for two years, and one, for one year — and the committee shall also elect a chairman and a vice chairman to serve for annual terms. In 1961, and each year thereafter, the president of the Society shall appoint one member for a term of ten (10) years to replace the member whose term expires. The president may appoint himself, or reappoint a member whose term expires if he so desires, but all appointees to the committee must be members in good standing of the Rhode Island Medical Society. In the event that a vacancy occurs on the committee, the president of the Society, with the advice and consent of the Council, shall appoint a member to complete the unexpired term of the member whose appointment is vacated.

"The Committee shall review all cases of threatened or instituted action for malpractice against any member of the Society, and shall also investigate all complaints concerning the professional conduct of members referred to it.

"The Committee shall have authority to require the attendance of any member before it relative to unprofessional conduct, upon not less than seven (7) days written notice to the member, and failure of the member to appear before the Committee without justifiable cause shall be reported to the Council of the Society for disciplinary action. The Committee, after investigation, shall have the authority to prefer charges of unethical or unprofessional conduct against a member to the Council."

Dr. Mara 101st President

A lifelong resident of Pawtucket, Doctor Mara completed his elementary and high school education in that city prior to his matriculation at Georgetown University from which he was graduated with a bachelor of science degree in 1931. Two years later he received his doctor of medicine degree from Georgetown Medical School.

He returned to Pawtucket for an internship at Memorial Hospital where he is now chief of the Department of General Practice and director of the Outpatient Department. He is also a member of the staff of Notre Dame Hospital in Central Falls.

A past president of the Caduceus Club, the Pawtucket Medical Association, the Memorial Hospital Staff Association, and the Memorial Hospital Interns' Association, Doctor Mara has long been active in the state medical society, serving as a member of its Council and House of Delegates for many years, as well as holding the chairmanship of the Committee on Social Welfare. He is also vice president of Physicians Service.

Dr. F. W. Dimmitt Named Vice President

Doctor Frank W. Dimmitt, secretary of the Providence Medical Association from 1943 to 1945, and president of the Association in 1950, was elected vice president. A graduate of the Uni-

versity of Texas and of the Texas Medical School, Doctor Dimmitt located in Providence after the completion of his two-year residency training at the Brooklyn Eye and Ear Hospital.

He is past president of the New England Ophthalmological Society, and he is a former surgeon-in-chief of the Eye Department at Rhode Island Hospital. Currently he is on the consulting staff at Rhode Island, Memorial, and Chapin hospitals.

Newporter Named President-elect

Doctor Samuel Adelson, who has served for two successive terms as vice president of the Society, was named to succeed Doctor Mara in 1961 as president. He has had a long and active career as a member of the Council and the House of Delegates of the state medical society. A past president of the Newport County Medical Society, Doctor Adelson has combined an outstanding civic career with that he has enjoyed in medicine. He has been chairman of the Representative Council of that City, secretary of the Board of Health, a member of the City Charter Commission, medical examiner in Newport County, and more recently, chairman of the Newport High School Commission.

Standing Committee Chairmen

Eight major committees, designated as standing committees, whose personnel is selected by the House of Delegates, were elected and officially inducted also. The following were named as chairmen of these committees: Industrial Health, Doctor Stanley Sprague of Pawtucket; Library, Doctor Francesco Ronchese of Providence; Medical Defense and Grievance, Doctor Francis B. Sargent of Providence; Medical Economics, Doctor Stanley D. Simon of Providence; Publications, Doctor John E. Donley, of Providence, who is also editor-in-chief of the RHODE ISLAND MEDICAL JOURNAL; Public Laws, Doctor Freeman B. Agnelli of Westerly; Public Policy and Relations, Doctor Arnold Porter of Providence; Scientific Work and Annual Meeting, Doctor Henri E. Gauthier of Woonsocket

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